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VOLUME 60

FEBRUARY 1943

NUMBER 2

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# HEADLINES

## PERSONNEL

Good news from Washington! Non-profit hospitals can raise wages wherever necessary to safeguard the health of communities without prior approval of W.L.B., subject, however, to final W.L.B. review, according to a January 24 decision.

A.W.L.B. order to pay \$87,500 in back pay to maintenance employees is the headache facing 11 San Francisco hospitals. (p. 124)

The federal government won't take on the responsibility of training auxiliary hospital workers. (p. 120)

Don't count too heavily on the fact that hospital employment has been listed as an "essential occupation" by W.M.C. This is a guide to draft boards, not a blanket deferment. (p. 114)

## ASSOCIATION

James R. Clark, superintendent of the Southside Hospital, Long Island, N. Y., heads the new War-Time Service Bureau of the A.H.A. starting February 1. (p. 122)

Meantime the nation-wide search continues for an executive secretary and for an editor. Final decisions on the two latter jobs may be made at the trustees' meeting in February. (p. 122)

## NURSING

A quota of 65,000 student nurses for 1943 has been set by the Health and Medical Committee. (p. 120)

To fill such a quota, we shall need much help. The A.C.S. and the National Nursing Council for War Service are providing excellent recruitment aids. (p. 126)

R.N., B.M.—those are the degrees of the postwar nurse as seen by Dr. Hugh Cabot. (p. 47)

## GROUP HEALTH

Although the Supreme Court decided against the A.M.A. in its fight with Group Health Association in Washington, D. C., there was little excitement about the case. So many doctors are now on federal pay rolls that others haven't time for arguments. (p. 45)

A new group health plan for New York City is announced. (p. 130)

Incidentally, "How to Organize Group Health Plans" is reviewed in this issue. (p. 140)

## PRICE CONTROL

Various of the price control orders affect hospitals. The most important is the transfer of health supplies to Maximum Price Regulation No. 188. (p. 106)

## SOCIAL SECURITY

Everybody, apparently, wants to amend the Social Security Act, judging by the large number of bills introduced and statements made by governmental and other leaders. Secretary of Labor Perkins on January 20 revealed some proposals by her department, such as cash benefits for all interruptions of employment and maternity and funeral benefits. (p. 104)

Blue Cross plans didn't quite reach the expected goal on December 31. But several slow-growing plans took a decided spurt in 1942. (p. 128)

## CONVENTIONS

The Mid-West group cancelled its convention; Pennsylvania's was shortened. But Texas and New England went ahead with plans, subject to federal orders. (p. 122, 126)

## FUEL

What looked like a hot conflict between the governor of Oklahoma and W.P.B. over fuel for a state hospital turned out on investigation to be due merely to inadequately prepared applications. (p. 116)

But hospitals in New York City were running dangerously low on both oil and coal. (p. 126)

## SALESMEN

The eligibility committee in the Gasoline Rationing Section of O.P.A. has turned down Everett W. Jones' request for additional gasoline for salesmen of hospital supplies, but says gas needed for repair and maintenance activities is available under present regulations.

## MEAT

Hospitals will not be quota-exempt in meat purchases, unless they are governmental institutions required to buy on bids. (p. 108)

## LABORATORIES

Everett W. Jones says hospitals must not use the order permitting purchase of "laboratory equipment" to obtain other things. (p. 110)

## FLOOR MACHINES

Take good care of your floor machines. No more will be produced for civilians after April 15. (p. 110)

## PHYSICIANS

Procurement and Assignment hopes to distribute the dwindling supply of doctors equitably. (p. 118)

But the Illinois Department of Registration refused even to give examinations to 127 graduates of European medical schools because they were graduated after July 1, 1936. This action was denounced by local newspapers.

*For full news coverage of the month, see news section beginning on page 104.*

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## FEARFUL

# February

According to medical records, most of the pneumonia in the United States occurs in February. Textbooks on pneumonia therapy, published only a few years ago, are unconvincing in the light of present knowledge. The empirical treatment formerly employed in the serious complications of respiratory infections has been replaced with the sulfa drugs. Chemotherapeutic agents especially effective against the pneumococcus are Sulfathiazole and Sulfadiazine. Both of these drugs are supplied under the Lilly Label in convenient dosage forms.

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# THE ROVING REPORTER

## It Grew Into a House Organ

Student nurses at the Parkland Hospital School of Nursing, Dallas, Tex., decided that they needed some way to let other people know what was going on in the school. The consensus was that a student newspaper would be a recreational outlet as well as the public relations medium they were seeking.

The students scoured the town for a reasonably priced printer; they spent much of their spare time sitting in department store offices soliciting advertising; they learned how to write, edit, proofread and make up the paper. Then there was the mailing list to compile—all other nursing schools in Texas, selected high schools and colleges, alumnae members and staff doctors.

When the first issue came out, copies were offered for sale at various points in the hospital. "Everyone from the superintendent to the newest orderly bought a paper," writes Student Nurse Majorie Moody in the *American Journal of Nursing*.

Came early spring and the senior nurses had heavier schedules; state board exams began to trouble them. There wasn't time to solicit advertising. In fear and trembling they went to the superintendent of the hospital to ask for partial support for their venture.

So well had they done a public relations job for the institution that the superintendent of the hospital and the city fathers offered to pay all expenses of the publication provided it would: (a) be the official organ of the hospital; (b) raise morale by creating friendlier relations among doctors, nurses, alumnae and members of the city-county hospital system; (c) encourage young women to enter nursing, and (d) be noncommercial. The girls now print 1000 copies per issue.

## Machines That Stand and Wait

Worth imitating by other hospital house organs is a feature in the Crouse-Irving Hospital Bulletin, Syracuse, N. Y., edited by Dorothy Pellenz. It is a photographic display entitled "Machines That Stand and Wait"; under each picture is a provocative legend, *Life Magazine* style. Says the introductory text:

"In various hospital rooms, sometimes in remote unlighted quarters, stand ungainly looking mechanical monsters. Hospitals are full of such contraptions: iron lungs, oxygen tents, x-ray machines, respiration apparatus, anesthesia machines, sun lamps, fever machines, rocking beds. To the average observer they

look like bad dreams but to the patient who needs them they are veritable fairies in disguise.

"Years have been spent in perfecting these machines. . . . It is partly because of scientific equipment standing and waiting that hospital charges must be what they are. But are not lives worth it?"

## Economy Exhibit

If you haven't had an exhibit on hospital economy lately, you are missing a bet. Take the "Interesting Exhibit of What Makes and Breaks Our Economy, Safety and Efficiency Program" put on by the Hospital of St. Barnabas and for Women and Children, Newark, N. J., as an example. All departments were invited. The nursing personnel, most vital influence in the economy program, was required to sign attendance sheets at the exhibit, which was held in the hospital conference room.

Engineers and maintenance men, dietitians and ward maids, house and attending staff, all had something to learn from the exhibit, a few placards from which are reproduced below.

### ADHESIVE TAPE on UNIFORMS AND APRONS

### CHEWING GUM in POCKETS!

These literally "GUM UP THE WORKS"  
Machines stop—Time is lost  
because

Some persons are NOT carefull

### ICE CAP FILLED WITH WATER SENT TO LAUNDRY

Cost of ice cap to the hospital is  
\$1.50

Careless handling of equipment not only  
is costly to the institution,  
but  
is characteristic of  
POOR NURSING

### GLASSWARE IS A HAZARD TO LAUNDRY EMPLOYES

### BAD LACERATIONS and BROKEN MACHINERY

are the result of dropping these things  
into the laundry hamper.

EXAMINE ALL LINEN Before  
EACH PICK-UP

## Bundles for Germany

Hospitals can't very well go in for Hollywood (footless) beds, but this newer note in bedroom decoration might be just the trick to make an antiquated nurses' home look a little more up to date.

What gives added zest to the suggestion these days is the converting of old beds made of metal into the Hollywood type. The essential surgery is done with a plumber's pipe cutter, the head of the bed being amputated just above where the spring rails are attached. Ornamental bedpost caps can be attached to the stumps or wooden plug-tops can be made for them.

The next step in the operation is to turn the bed around, using the foot rail as the head. Made up with an attractive spread the rehabilitated bed looks definitely 1943.

The amputated bed heads, of course, are piled on the local scrap heap as a surprise gift for Herr Hitler.

Author of the foregoing idea, which was reported in *Hotel Management*, was Morris H. Block, owner of Hotel Vail in Pueblo, Calif. He contributed two tons of scrap metal from his hotel, meanwhile improving the appearance of the place measurably.

So enthused was Mr. Block over his project that he trained a group of volunteer Pueblo citizens, men and women, to perform the operation on old metal beds and with their cutters these persons made house to house calls, salvaging a ton of metal a day.

## Women Employees Tagged

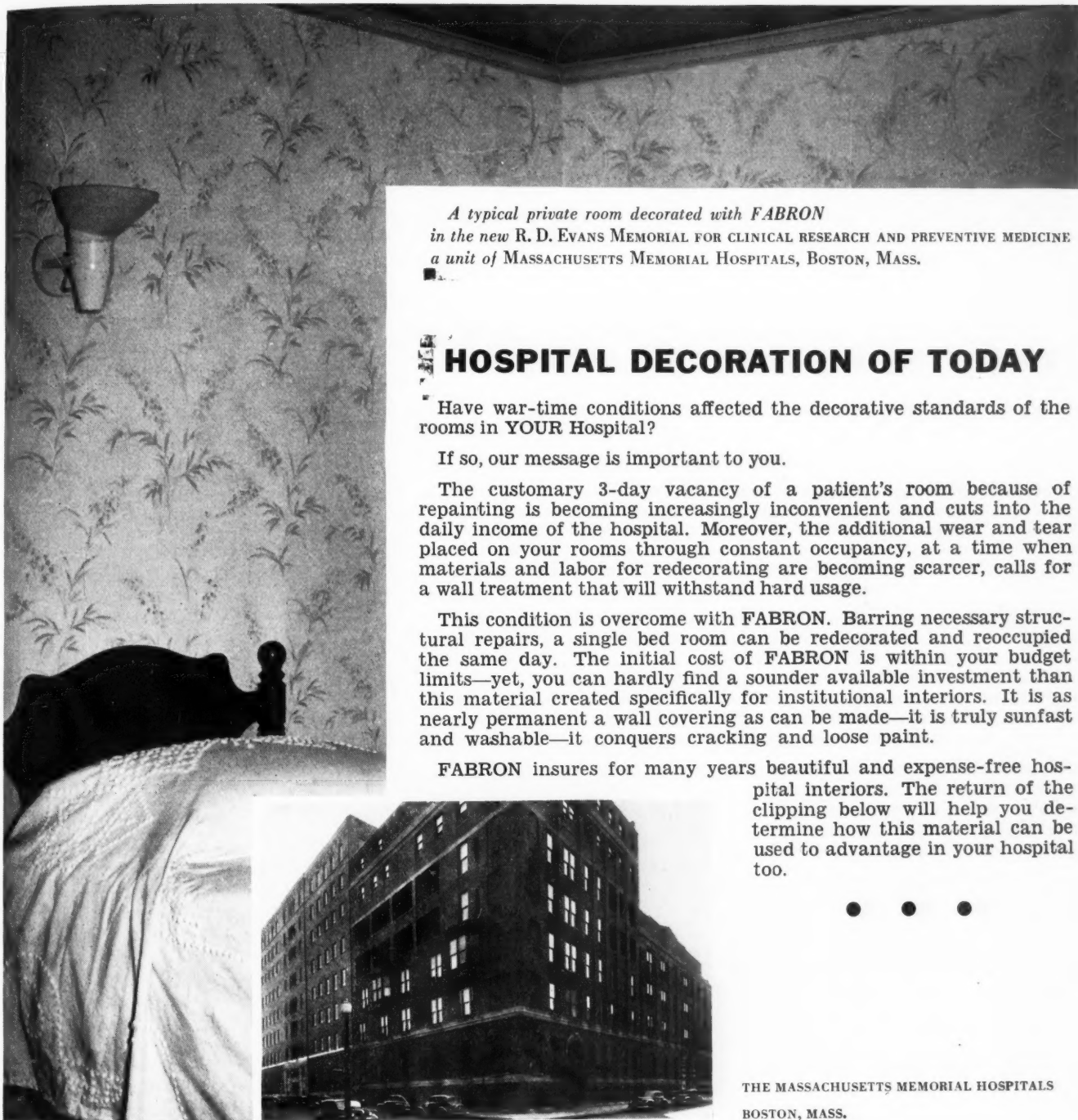
New stock in the general store at Massachusetts General Hospital, Boston, includes inexpensive identification tags.

The difficulties that were encountered in identifying women patients in the Cocoanut Grove fire, reported on in the last issue, inspired Dr. Nathaniel W. Faxon to send out a request to all women employees of the hospital to provide themselves with an identification tag at once. Such a tag should give the complete name on one side and the person's blood type on the other.

Immediate identification of persons involved in accidents will spare relatives and friends harrowing experiences and "the useless hope of doubt," Doctor Faxon declared.

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If so, our message is important to you.

The customary 3-day vacancy of a patient's room because of repainting is becoming increasingly inconvenient and cuts into the daily income of the hospital. Moreover, the additional wear and tear placed on your rooms through constant occupancy, at a time when materials and labor for redecorating are becoming scarcer, calls for a wall treatment that will withstand hard usage.

This condition is overcome with FABRON. Barring necessary structural repairs, a single bed room can be redecorated and reoccupied the same day. The initial cost of FABRON is within your budget limits—yet, you can hardly find a sounder available investment than this material created specifically for institutional interiors. It is as nearly permanent a wall covering as can be made—it is truly sunfast and washable—it conquers cracking and loose paint.

FABRON insures for many years beautiful and expense-free hospital interiors. The return of the clipping below will help you determine how this material can be used to advantage in your hospital too.

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## READER OPINION

### Objection Sustained

Sirs:

The excerpts from the approved summary of the discussion of the technical committee which met in Washington, D. C., September 3 and 4, appearing in the December 1942 issue of *The Modern Hospital*, might, to the hasty reader, imply that the committee really did meet to "preview" compulsory hospital insurance, as the title of the article suggests, and that it agreed that there was "little danger to Blue Cross plans under such a program," which is indicated by a subhead.

The *MODERN HOSPITAL* has been too good a friend of Blue Cross plans and all voluntary nonprofit hospital plan activity not to call to your attention the possible mistake in emphasis that these items imply.

We did not "preview" compulsory hospital insurance. We considered technical problems of a program that was then only in the discussion stage. Social Security Board representatives accepted responsibility for the ideas as their own. When we met, the Eliot Bill had not been proposed, although the agenda followed might have been an outline of the Eliot Bill, so closely did the ideas in the bill resemble the agenda material. We were assured that the details of a plan favored by the Social Security Board had not been formulated as proposed legislation.

While majority opinion was to the effect that a compulsory hospital insurance program, if included under the Social Security Board, would result in "little danger to Blue Cross plans," the representatives of hospitals were in agreement that the continuance of voluntary insurance was important to the maintenance of the voluntary hospital system. The hospital representatives reiterated that America could best be served if the voluntary hospital system were expanded and made more perfect.

The Bishop resolution and the six-point program, both adopted by the house of delegates of the American Hospital Association in St. Louis, revealed the kind of statesmanlike approach to a social problem for which we have all hoped. The will of the association requiring that present inadequacies of hospital service be met by voluntary means was expressed with courage and conviction. The hope of the association that plans will play an important part in the solution of this problem is not quixotic. The Blue Cross plans are already paying American hospitals \$50,000,000 a year, 10 per cent of their national income.

Even if it can be demonstrated that all people cannot eventually belong to

Blue Cross plans, the merging of voluntary and governmental sources of support to hospitals can result in complete coverage. The special advantages of initiative in research, standards of service and economy of operation can be retained if Blue Cross plans are given encouragement.

Blue Cross plans are not against government participation in financing hospital care. Blue Cross plans are simply a natural development of buyer and seller, subscribers and hospitals. If allowed to develop, the plans will distribute the benefits of hospitals on a wider, more equitable basis and still preserve the driving force of local action in financing this necessary care. The kind of assistance program our hospital problem boils down to at the present time does not require compulsory hospital insurance.

E. A. van Steenwyk  
Chairman

Associated Hospital Service of  
Philadelphia

### Doctors on the Board

Sirs:

The articles which appeared recently in *The Modern Hospital* regarding physicians on the board of directors leave some things to be considered.

The primary function of a hospital is still to get patients well. Inasmuch as the control of these processes and the requisite knowledge are both functions rightfully belonging to the physician, it follows axiomatically that the function of the hospital in every department is to aid the physician in treating his patient.

If this is true, many hospitals have gone far afield. The superintendent, the social service department, auxiliaries, directresses of nursing, residents, nurses, telephone operators, various clerks, anesthetists and the board all seem to be able to tell the physician what to do.

Doctors are as good business men as business men think they are. Consider the hundreds of banks and business houses that failed in the last depression. Doctors, however, continued to do their bit and practice medicine as usual.

Doctors with business tendencies should take some special training in business administration, hospital or hotel management as an aid to their respective boards. Business men with real vision should be on the board. These two groups should be equal in number, equal in authority and should meet together.

Frederick E. Keller, M.D.  
Associate Medical Director

Anderson Hospital  
Philadelphia





## *"Old Ties Are Best"*

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# SMALL HOSPITAL QUESTIONS

## Assigning Night Duty

Question: How much time should a night graduate nurse have off? How can night work be made attractive to registered nurses?—N.E.McK., N.Y.

ANSWER: A night graduate nurse should have one full night off each week with an additional night one week each month.

I sincerely doubt whether night duty can be made more attractive to a registered nurse. Additional time off is sometimes offered and additional compensation is often offered, but neither of these seems to make it more attractive. It depends largely on the personality of the nurse; two of our nurses would rather work nights and have done so for some months. In all other cases we rotate the shifts each month so everyone has her share of night duty.—W. H. HUNT.

## Supplements for Retirement

Question: What are hospitals doing for the security of their employees and their families in the way of retirement plans?—M.E.K., Tex.

ANSWER: A spot check survey in 1940 indicated that less than 1 per cent of American hospitals had retirement plans for their employees. More interest has been taken in this subject in the last two years and a number of hospitals have made retirement annuity plans, underwritten by major insurance companies, available to their personnel.

It is probable that within the next year or two the present exemption of charitable institutions will be removed from the Social Security Act insofar as retirement annuities are concerned. In any event, it is desirable that a hospital should, if possible, supplement the social security benefits by a voluntary retirement annuity program for its employees on a basis of joint payment by hospital and employee.—BASIL C. MACLEAN, M.D.

## Dietitians to Know Diet Likes

Question: In a 60 bed hospital, is it the duty of the dietitian to visit each patient and find out about his preference as to drinks and nourishments or should the supervisor on the floor be responsible for furnishing this information to the dietitian?—P.A.S., Ark.

ANSWER: Why have a division of responsibility? It is the dietitian's responsibility to see that each patient is pleased with the tray and nourishments set before him. The individual likes and dislikes of patients must be known by the dietitian and the best way for her to learn of them is from each patient personally. The dietitian's visit is a wonderful public relations builder for only she can answer the many questions patients have about their trays and the kitchen.

Incidentally, in a 60 bed hospital,

Conducted by Gladys Brandt, R.N.,  
Children's Free Hospital, Louisville,  
Ky.; Jewell W. Thrasher, R.N.,  
Frasier-Ellis Hospital, Dothan, Ala.;  
William B. Sweeney, Windham  
Community Memorial Hospital,  
Willimantic, Conn.; A. A. Aita,  
San Antonio Community Hospital,  
Upland, Calif.; William J. Donnelly,  
Greenwich Hospital, Greenwich,  
Conn., and others

operating under present conditions, the nursing staff probably has its hands full with nursing problems and has little time or desire to talk with patients about their diet likes and dislikes.—W. H. HUNT.

## Charging for Binders

Question: When surgical patients are sent home wearing binders, should they be charged a flat fee for the binder or should they pay a deposit to be refunded when the binder is returned?—E.B., Mich.

ANSWER: Probably the more satisfactory method is to charge a flat fee.—JEWELL W. THRASHER.

## Where to Find Nurses?

Question: How and where can small hospitals obtain graduate nurses?—Sr.M.A., Kan.

ANSWER: The two main sources through which graduate nurses are employed are through official registries located throughout the nation and the directors of schools of nursing. Writing to a nursing school often is quite a satisfactory method of obtaining nurses.

Both small hospitals and large should bear in mind that we face an acute shortage of nurses and we may not be able to obtain enough to fill all vacancies.—JEWELL W. THRASHER.

## Librarians Are Necessary

Question: Is it practical to employ a full-time records librarian in a hospital of 100 beds or less?—O.H.O., N.D.

ANSWER: It is not only practical but necessary to employ a full-time medical records librarian in a hospital of 100 beds or less. A registered librarian should be employed and the medical records department assigned as her primary responsibility. Secondary duties may be assigned if the medical records department does not have sufficient work to keep the librarian busy.

If the department is properly organized and does all the work that is the responsibility

of that department, there will not be much time for other duties in a hospital with a daily census of 85 to 100 patients. In addition, the medical records librarians are being called upon to assist physicians by taking dictation during the present emergency, thus helping to keep up the standards of the medical records and necessitating the availability of a qualified person.—MRS. EDNA K. HUFFMAN.

## Play for Cardiac Cases

Question: Can you give me a list of books or pamphlets on the subject of play activities for children with cardiac diseases?—H.L.T., Ill.

ANSWER: We do not know of books written especially about the play activities of the cardiac child. However, the following is a list of references we assign to our nurses. Parts of these books and articles are concerned with cardiac cases.

The degree of activity of our children is prescribed by our physicians and the nurses regulate the play and recreational activities of the children accordingly.

Boyd, Neva L.: *Handbook of Games*. 50 cents.  
Boyd, *Hospital and Bedside Games*. 50 cents.  
Boyd, *Schoolroom Games*. 25 cents.

*Finger Plays for Young Children*, Leaflet No. 11. Institute for Child Welfare. Minneapolis. 3 cents.

*Children's Playthings and Books*. Edited by the department of research, Household Finance Corporation, 919 North Michigan Avenue, Chicago. 3 cents.

*Mental Games*, Kit E. Edited by Lynn Rohrbough, Cooperative Recreation Service, Delaware, Ohio. 25 cents.

*Ancient Games*, Kit N. *ibid*.

Bishop, Louis Faugeres Jr., M.D.: "Hobby Guidance for Children With Handicapped Hearts," *Occupations*, December 1935, p. 233.

Holt, Edward Z.: "Something to Do," *Hygeia*, December 1939, p.1084.

Smith, Anne M.: "Psychologic Importance of Play in a Children's Hospital," *Archives of Physical Therapy*, June 1939, p.361.

Richards, Susan S. and Wolf, Ernst, M.D.: "Organization and Function of Play Activities in the Setting Up of a Pediatric Department," *Hygiene*, April 1938, p.334.

Kawin Ethel: "Play Therapy for Special Needs," *The MODERN HOSPITAL*, April 1940, Pp. 61-63.

Kawin, "Play Therapy, A New Science," *ibid*, June 1939.

Alschuler, Rose H., and Hattwick, Laberta A.: "Amusing the Sick Child," *Hygeia*, April 1938, p.334.

Bishop, Louis Faugeres Jr., M.D.: "The Child Who Has Heart Disease," *Hygeia*, July 1939, p.597.

Kern, Bernadine: "How to Organize a Play Department in the Hospital," *Hospital Management*, April 1939, p. 35.

—ALICE M. MORSE, R.N.

## Allowance for Married Nurses

Question: Are married nurses who live outside the hospital given an extra salary allowance for rooms?—E.Z.M., Calif.

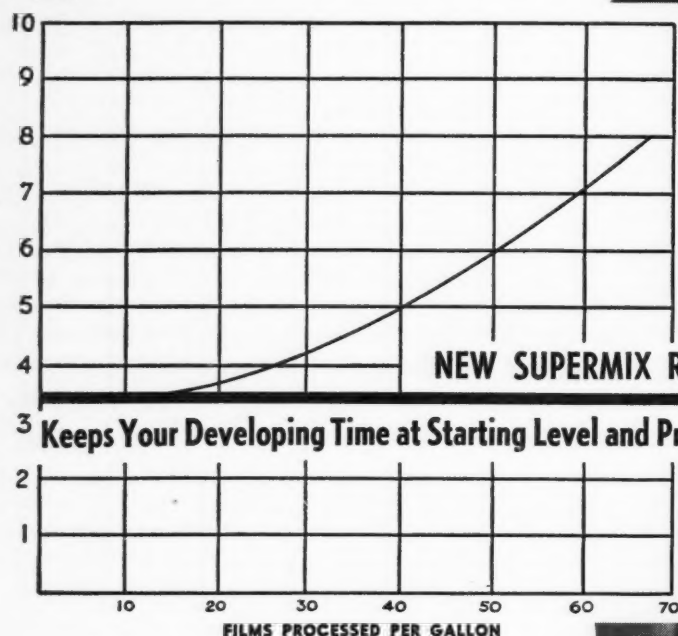
ANSWER: Yes; we allow \$20 per month for room and laundry.—OLIVER H. PRATT.



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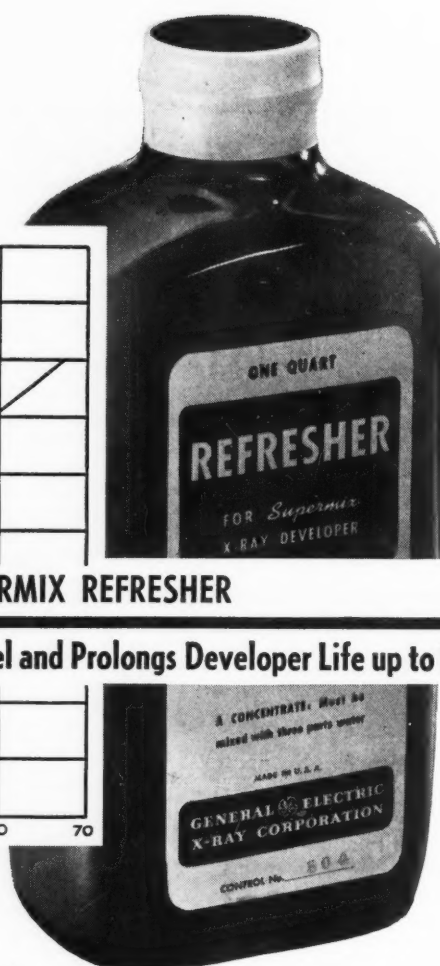
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## LOOKING FORWARD

### Supreme Court Decides

THE long trial of the American Medical Association and the District of Columbia Medical Society on charges of a conspiracy "to restrain trade" has at last been brought to a close. The Supreme Court of the United States in a unanimous decision, with two judges taking no part, has held the two medical societies guilty. All concerned will doubtless now be relieved that the case is finally settled.

What are the implications of this decision? Probably no one can know. It may mean a considerable increase in the organization of voluntary group practice, group payment plans. It seems rather unlikely, however, that the particular form of organization taken by Group Health Association, Inc., namely, a consumers' cooperative, will be widely followed. While there are several thousand consumer cooperatives in the United States, most of them are too small to undertake the heavy responsibility of providing medical and hospital service. Nor would it be socially desirable to have the field filled with a great number of small competing organizations. The pattern of state-wide or region-wide organization set by the Blue Cross plans seems much more economical and efficient.

The decision, of course, will stop the American Medical Association from using its approval for internships and residencies to coerce hospitals into denying facilities to physicians entering medical group arrangements of this type. This practice was apparently stopped some time ago.

### Saving for a Sunny Day

IT IS not mere starry-eyed dreaming to begin now to think of the postwar world, especially the hospital service that will then be required. Doubtless there will be a program of public work projects to cushion the transition from war to peace economy. If voluntary hospitals are to participate in this expansion program, we should prepare now. Let's think carefully about the basis for determining needs, standards of construction, physical equipment and service and

then formulate a long-range program designed to meet more adequately the needs of all types of people in our areas. Let's have as much of the preliminary planning and discussion out of the way as we can.

If the federal government provides funds for such projects, it doubtless will require speedy spending of these funds. Probably, it also will require that they be matched in part by local funds. Hence, it is important for every hospital to accumulate, as rapidly as it can, a reasonable sum for postwar spending. Even if there should be no federal funds to be matched, hospitals have been blocked in the purchase of much new heavy machinery. Money should be on hand to make up these deficiencies promptly when such equipment again is available.

### People on the Move

AN INDUSTRIAL leader, head of a large company interested in the construction field, recently outlined one aspect of the postwar world as he sees it.

"With the end of the war we will have again a redistribution of population requiring new cities, new towns, new living areas and new living quarters, as well as the reshuffling and reconstruction of living quarters in many of the old sections that may be continued. It is my belief that this will necessitate the building or rebuilding in the United States of 10,000,000 or 15,000,000 family units of new or reconstructed houses, the cost of which will probably reach the enormous sum, in dollars, of more than twenty billions."

Maj. Alexander de Seversky predicts that the full impact of our transition from the ground age to the air age will affect and change all aspects of American life—city planning and development, education, manufacture, transportation, cultural contacts and our entire outlook.

From other parts of the industrial front there are indications that new methods and new materials will change the face of our cities, at least, in the next generation and perhaps of the countryside, too. Decentralization of industry and of housing will probably be greatly speeded.

What will all these developments mean to the hospital world? They will doubtless mean, for one thing, that new types of hospitals will be built following the war with many refinements not now visualized. Probably for the same or less money, we can have more efficient, more sanitary and more attractive hospitals than we have ever known.

There will be new areas and new population groups to be served, also. That will present us with the problem of deciding whether it is wiser to bring the patient to the large well-equipped central hospital or bring a smaller hospital close to the patient. Probably both actions will be taken through a closer linking of the outpost hospitals with the large medical center. Swift, smooth transportation may play an influential part in the decision. Regional coordination of hospital and health facilities, long dreamed by public health statesmen, will probably become an accepted principle.

Nothing has been said of the tremendous developments in the clinical field that will undoubtedly come out of the war. Every previous war has accelerated medical discovery; this will be no exception. New preventives as well as cures will add to our armamentarium. The hospital of the postwar world will find itself becoming a health center, as concerned with preventive medicine and public health as its present day counterpart is with palliation and cure.

## Obstacles to Public Medical Service

THE poll of public opinion conducted by the American College of Hospital Administrators, results of which appear in the October and November issues of this journal, indicates that many hospital administrators are eager to have governmental agencies assume all or a major share of the cost of caring for indigent patients. They believe that such an arrangement will safeguard the financial position of the voluntary hospital.

There is no longer any question that this is necessary, although there still is considerable question among the leading philosophers of hospital service whether we should insist on the last pound of flesh or be satisfied at a somewhat smaller figure. But in most areas, payments are so far short of cost that that problem seems more or less academic.

As we move toward fuller payment for the indigent several problems must be solved. In her report on public medical services to the American Public Welfare Association, Dr. Gertrude Sturges states these problems as she saw them after an extensive survey.

"Division, overlapping and duplication of governmental authority for similar functions comprise problem No. 1," she states. "In one eastern state 12 independent state agencies are involved in the administration of public medical service. Five of these agencies make payments to nongovernmental hospitals, at different rates, incidentally. In a central state, three departments operate hospitals, while a fourth and fifth are

responsible for payment to voluntary hospitals for the care of special categories of disease; two additional authorities in each county, acting independently of any state authority, make payments to voluntary hospitals."

Divisions are sometimes functional, sometimes by medical categories and sometimes by economic class. As Doctor Sturges points out, such scattering of administrative responsibility results in confusion, inefficiency, waste, delay, lack of continuity in care and duplication or gaps in service. Hospital administrators gave eloquent testimony in the recent poll to the seriousness of these difficulties.

Another problem stressed by Doctor Sturges is the need for medical advisory committees, including all of the professions and voluntary agencies concerned. Such committees usually include physicians, sometimes dentists and pharmacists, and only rarely representatives of voluntary hospitals, visiting nurse associations and medical social work agencies. When the advisory committee is well balanced, the medical care program is much more likely to be well balanced.

Voluntary hospitals, in their rightful demand for more tax aid, must recognize that this means quite properly more supervision over their work from the professional, financial and social points of view. Thus hospitals will have an increasing stake in the quality of administration and supervision of public medical programs and should insist that such programs be administered by persons who have had professional training in medicine, public health, hospital administration, public health nursing, medical social work or some similar field.

## Administrator's Progress

THE American College of Hospital Administrators has just published a "progress schedule for a nominee." This is an interesting and constructive way to stimulate nominees to carry on activities of a kind that will qualify them for advancement to membership and later to fellowship.

The schedule asks the nominee to outline what he is doing this year to become more proficient in the performance of his present position. This question is one we all might ask ourselves, now and periodically in the future. Some of the methods that might be followed are indicated by the further questions in the schedule.

These concern reading of magazines, pamphlets and books, enrolling in correspondence study courses, evening courses or other formal continuation study, making observation tours, attendance at institutes and hospital meetings, writing articles, outside activities which add to perspective or service as officer or committee member in a hospital association.

The college will spread its influence more widely if it follows up vigorously with its nominees, giving them guidance and encouragement in their programs of self-advancement.



# Future of Nursing Education

THE professional services rendered by physicians and nurses are essential social services. They must be closely integrated with contemporary social conditions and very sensitive to social change.

One does not have to be a prophet to advance the opinion that great social changes have taken place in this country and that still more fundamental changes lie immediately before us. From this it seems to me to follow that unless the professions of medicine and nursing so plan their educational offerings as to keep at least in step with social change they are likely to fail the country in the time of its greatest need.

The present day nursing education with the three year hospital course leading to a R.N. is essentially patterned upon the status of medical practice during the last twenty-five years. In the earlier days of the training schools for nurses the graduates were trained for the private practice of nursing. Much of their time after graduation was spent in home nursing and, as compared with the present day, relatively little in hospital nursing except in administrative positions.

## Demand for Nurses Will Increase

The rapid increase in the utilization of hospitals, for both diagnosis and treatment, has enormously increased the demand for hospital graduate nursing and with this has come a great decrease of the utilization of nurses for home care. The present standard three year course in nursing produces specialists essential to the modern practice of scientific medicine. In many respects these graduates are junior practitioners of medicine and invaluable assistants and associates of the physicians. Just as an increasing amount of the practice of medicine is carried on in and about hospitals so an even greater amount of the practice of nursing is carried on in the same environment. There is no probability that this demand for hospital nurses will

*The degree "Bachelor of Medicine" appropriately indicates the status and training of the nurse of tomorrow and her relation to medical service as a whole*

## HUGH CABOT, M.D.

diminish; in fact, it is likely to increase and thus the demand for women with this type of training must continue to be met.

But no one can have lived in close touch with our changing social conditions without having noted that there is clearly evident a change in the accent on medical practice with an increasing shift from diagnosis and treatment to prevention and positive health. We have come to realize that, though the diagnosis and treatment of illness is an essential requirement of medical practice, the maintenance of a healthy population and the use of the scientific possibilities that have been placed at our disposal will require of the medical profession, in the immediate future, thorough application of preventive medicine in all its ramifications, much more attention to nutrition and other sound principles of living and much more interest in positive health than has been the case in the past. This will constitute an enormous addition to the burden already carried by physicians and their associates and will obviously require a large increase in personnel.

At first sight it might seem as if this increase would have to be largely in the number of physicians and in their more satisfactory distribution. On the other hand, modern medical education requires a long and expensive training and we shall be well advised to consider whether such an increase is either necessary or desirable. Much of the work that will be added—I think, in the immediate future—will consist of the collecting of fact, the giving of instruction and

general supervision of living conditions without which no sound program of health can succeed. I am firmly of the opinion that much of this work can be done not only as well but better by women with an appropriate training. But I do not think that the present training, aimed as it is chiefly to produce experts in hospital nursing, will fill the bill.

## More Work in Public Health Needed

What I have in mind will come under the general heading of public health nursing though it will not, as I think, correspond accurately with the work now done by nurses trained in public health schools. The nurses, of whom there should be in my judgment a large number, should have a training much broader than is now given to the candidate for hospital nursing. It should be less special, should cover much more of the field of preventive medicine, provide much more familiarity with normal health, and it must provide a sound background in the understanding of social conditions. Such training cannot easily be articulated with the present standard course given in hospitals, which is still considerably on an apprentice basis.

The nurse who is to participate largely in the newer programs of preventive medicine and positive health will have to know something more of the fundamentals of medical practice. She will have to be something approaching an expert on the problems of nutrition. She will have to know a great deal of the problems of social adjustment, of personality problems, of the methods of adjusting children—those new-

comers into a strange world—to their environment, and she will have to be almost a capable practitioner of preventive medicine. Much of her time will probably be spent in the home of the patient studying the conditions, familiarizing herself with the personalities of the family and advising as to how a meager income may be made to supply a satisfactory environment for normal healthful living.

I have long believed that women are, on the whole, better suited than men to studying environment, giving the appropriate advice and feeling their way along deftly in complicated and varying conditions of environment. All these things used to be done in a simpler world by the general physician, but it is many years since the increasing burden placed upon the physician by modern science has made such a rôle for him possible. Moreover, our knowledge in all of the fields broadly covered by the phrase "preventive medicine" has increased to such an extent that, with proper and detailed supervision, much disease can be permanently avoided and many conditions which are not properly described as disease but which undermine health and diminish working capacity can be headed off and re-

placed by positive health. However, these things cannot be done by the personnel now available.

I make bold, therefore, to suggest that here is an essential field for which women with a sound training are peculiarly fitted. I would even go further and suggest that, unless some such development takes place, care of the health of the people that is thoroughly in step with modern scientific knowledge cannot be given.

Here, then, is the requirement not for the creation of a new profession but for the extension of the work now being done by nurses commonly thought of as working in the field of public health. As already suggested, I do not think that appropriate training can be provided with the machinery now at our disposal. I am convinced that this training should be placed, where many believe nursing education should long since have been placed, on an academic basis. The schools that should give this training will, I think, as a rule, have to be parts of well-established universities which already have, as part of their organization, medical schools and hospitals.

I should be hopeful that a carefully planned course could be compressed into four years though there

will be great temptation to try to put such a training on top of that now offered in the hospitals. This would, I think, be a mistake and will make it difficult to avoid waste of time and loss of balance and to provide a well-rounded, because single-minded, educational plan.

As I have already suggested, these people will be even more involved in what is properly regarded as the practice of medicine than are the trained nurses of today. We, in this country, have made but little use of the degree Bachelor of Medicine. This would, I believe, be an appropriate indication of their relation to medical service as a whole. It would suggest that they did not have the elaborate scientific equipment of the physicians but, at the same time, would make it abundantly clear that they were involved in the practice of medicine and were essential cogs to anything approaching complete medical care in step with modern science.

I think this problem is urgent for I am convinced that we shall find ourselves in the postwar period with an urgent demand for great extension of medical care and a supply of physicians and nurses who are not equipped by training or experience to carry out successfully important parts of the schedule. I am aware that the setting up of such schools cannot be done overnight, that it is not every university that can provide the equipment and environment and that there are still fewer that could face with equanimity the expense involved. I, therefore, humbly suggest that this is a major problem for the U. S. Public Health Service and that funds to start and to maintain such schools will probably have to be provided by the federal government since I see no other agency that could set up the number of schools necessary and provide for their proper geographical distribution.

To those who believe that this is the vision of a starry-eyed idealist, I commend a thoughtful study of the evidence that the American people are ill-satisfied with the medical service now at their disposal, that there is an extraordinary unanimity of opinion at all levels to the effect that improvement of the service is long overdue, and that there is behind this conviction a weight of opinion that is likely to demand action.

---

## Must We "Call a Meeting"?

NOW that so many other commodities are being strictly rationed and so much of the administrator's time is being taken up trying to run his hospital with all the limitations, would it not be a good idea if we undertook to ration the amount of our time required by meetings?

The nature of our problems, of course, requires that we exchange ideas and attempt to develop uniform policies but, more than ever before, it is necessary to restrict the number of hours that we spend on these joint discussions, particularly where traveling to and from meeting places is required.

My suggestion would be that any administrator who is thinking of calling a meeting should first consider carefully whether the subject is

important enough to call people together or whether the purpose cannot be solved by a simple questionnaire or telephone canvass. If the matter is important and time can be saved by joint discussion, then the hour and place should be determined with reference to the greatest economy of time and the agenda should be prepared with a view to presenting the problem in concise and simple terms.

President Nicholas Murray Butler of Columbia defined administration as "the art of doing well many things which need not be done at all" and I wonder if we should not apply this test to ourselves whenever we are moved "to call a meeting."—F. STANLEY HOWE, *administrator, Orange Memorial Hospital, Orange, N. J.*





Photographs by Nowell Ward

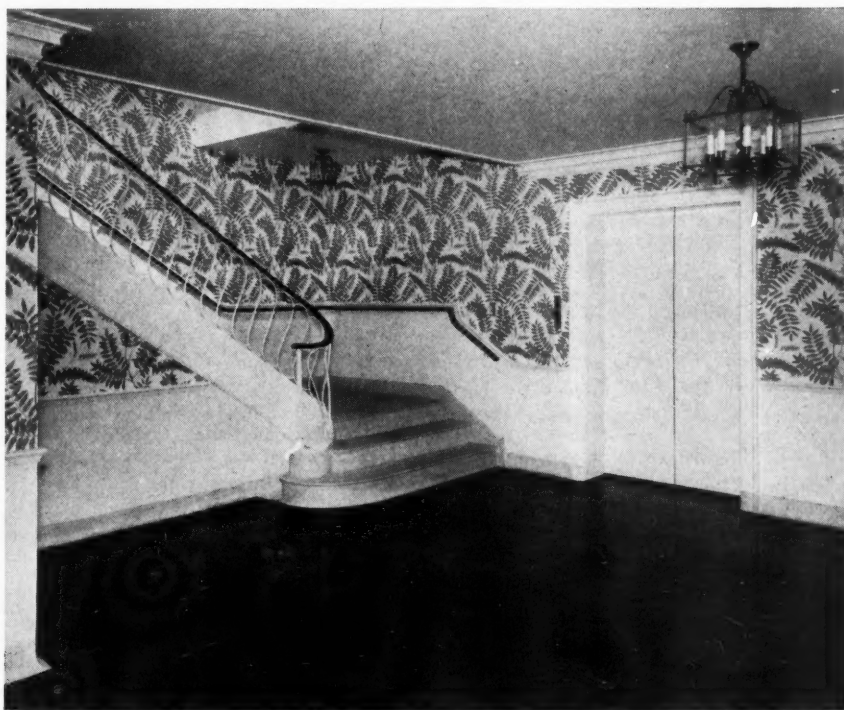
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### CONSTRUCTION DETAILS



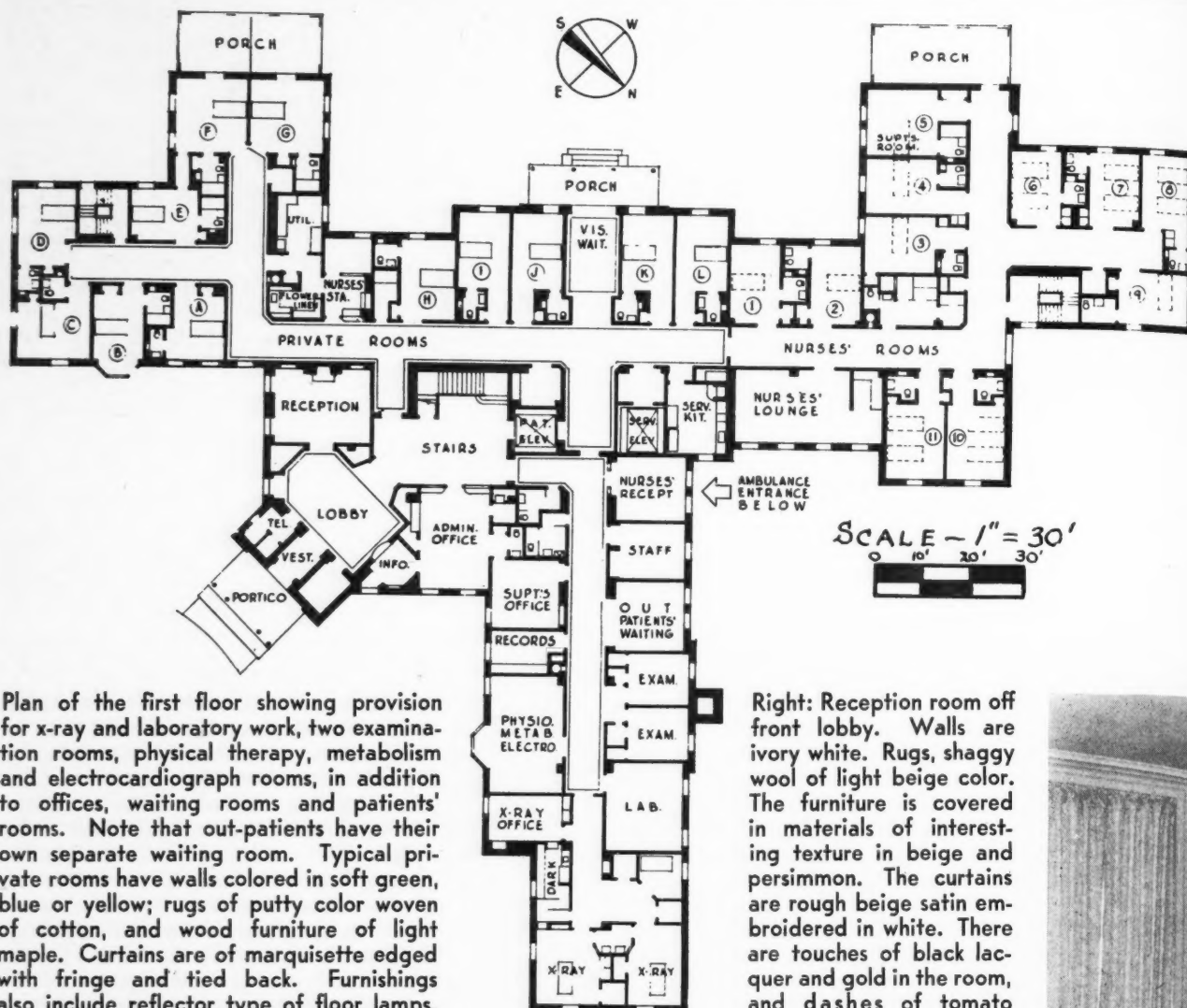
ELEVATOR HALL AND STAIRWAY JUST OFF THE LOBBY

**GENERAL DATA:** 60 bed general hospital (succeeding Alice Home Hospital) and serving population of 11,000 people in northern suburbs of Chicago. Located on 24 acre site approximately two miles from city center. At present only 40 beds are open for patients, remainder being used to house nurses. Kitchen, heating plant, sewage disposal plant, 5 car garage (with apartment for groundkeeper and bedroom and bath for night fireman) and other service facilities built to serve future hospital of 76 beds and 30 bed nurses' home. Two one story wings can be added when needed to increase hospital capacity by 16 beds. Third floor of hospital houses part of domestic staff and has lockers, showers and dormitory for six special duty nurses.

**CONSTRUCTION:** Fireproof reinforced concrete with steel skeleton, hollow tile partition walls, complete insulation. Exterior, Williamsburg brick. Windows, double-hung wood sash with white marble window stools. Fireproof all-steel stairways. Roof, steel beams and precast concrete slabs covered with slate.

**FLOORING:** Terrazzo, coved throughout; rubber tile in corridors with terrazzo borders.





Plan of the first floor showing provision for x-ray and laboratory work, two examination rooms, physical therapy, metabolism and electrocardiograph rooms, in addition to offices, waiting rooms and patients' rooms. Note that out-patients have their own separate waiting room. Typical private rooms have walls colored in soft green, blue or yellow; rugs of putty color woven of cotton, and wood furniture of light maple. Curtains are of marquisette edged with fringe and tied back. Furnishings also include reflector type of floor lamps, bureau lamp and adjustable bed lamp.

Right: Reception room off front lobby. Walls are ivory white. Rugs, shaggy wool of light beige color. The furniture is covered in materials of interesting texture in beige and persimmon. The curtains are rough beige satin embroidered in white. There are touches of black lacquer and gold in the room, and dashes of tomato color, that lend character.



Tile wainscots finished flush with plaster to avoid dust-catching projections. Quarry tile in kitchen.

**CEILINGS:** Hollow metal pan acoustic tile in alternate (checkerboard) blocks in corridors, delivery suite, auditorium, x-ray rooms, kitchens, nurses' stations and other work areas.

**WALLS:** Plastered.

**HEATING, AIR CONDITIONING AND POWER:** Hot water heated by high pressure steam. Convactor type of copper coil radiators with individual thermostatic control in patients' rooms and professional areas; remaining areas controlled by outside thermostats. Air conditioning in surgery, nursery and obstetric units with 10 ton water-cooled central refrigerating unit. Two 125 h.p. oil-fired high pressure steam boilers with high pressure steam for laundry, kitchen and sterilizers. Emergency automatic electric generator, steam operated, for lights in operating rooms, obstetric department and corridors. Oil-fired incinerator. Cork insulated ceiling over power plant. Electric power from public utility brought in by two separate power lines.

**CALL SYSTEM:** All silent light system for nurses' call. Doctors' in-and-out registry at

front entrance and basement entrance, flashing system. Wiring roughed in for doctors' call system but outlets have not yet been installed.

**LIGHTING:** Individual adjustable indirect bed lights with reading spot (also reversible for examination and removable for use as hand light). Utility and night light outlets only in each patient's room. Night lights in corridors. Indirect lighting in workrooms, examining rooms and similar areas. Fluorescent lighting in few desk lights. Twin-circuit overhead operating room lights.

**ELEVATORS:** One passenger and one service automatic or attendant operated, self-leveling elevators from basement to second story. One dumb-waiter from kitchen to first and second story.

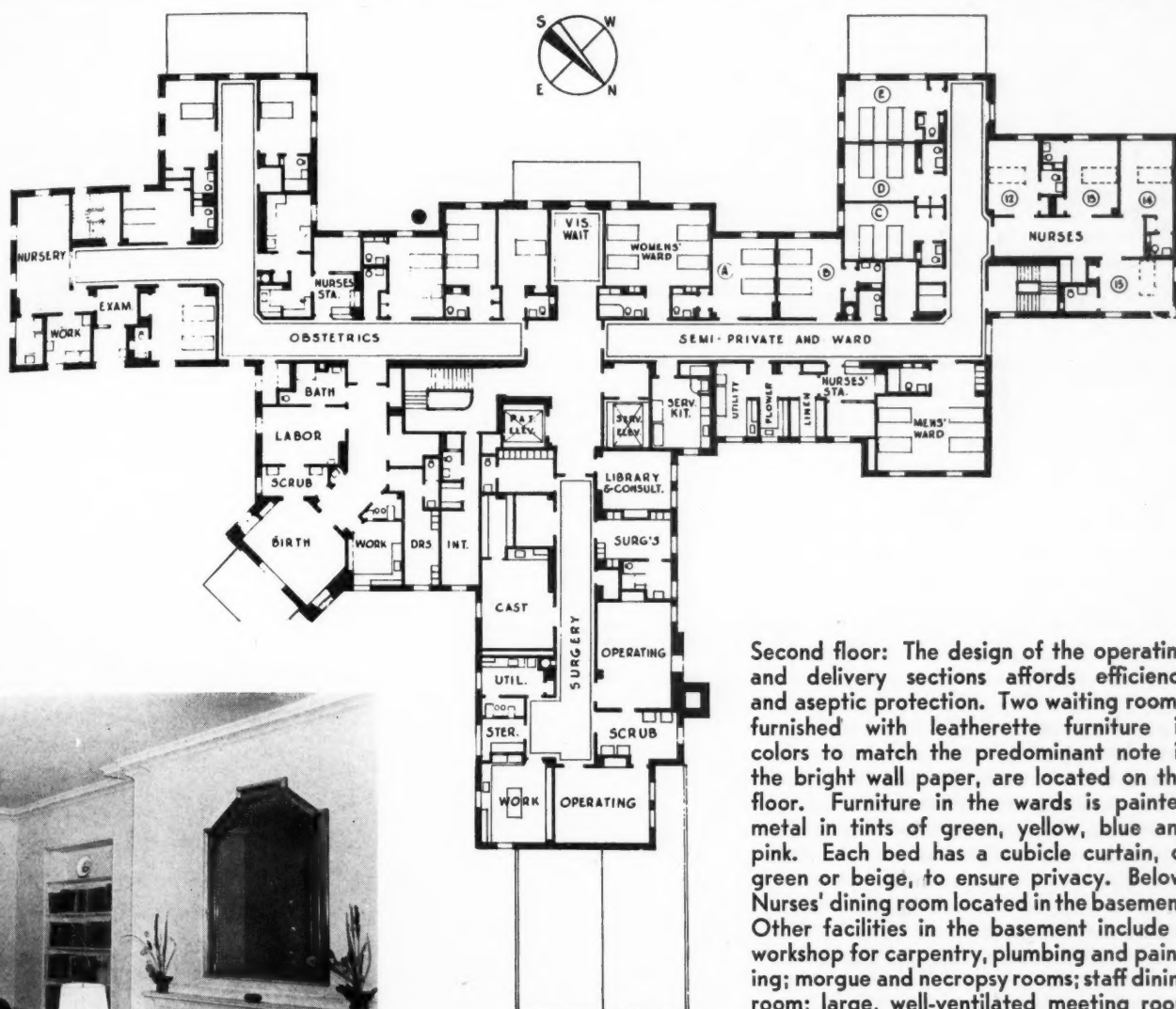
**X-RAY EQUIPMENT:** One 200 kv. therapy machine and one combination radiographic and fluoroscopic machine. One portable unit.

**REFRIGERATION:** Individual units in diet kitchens, laboratory, workrooms and formula room. Walk-in main kitchen and food storage room refrigerators with water-cooled central compressor; stainless steel exteriors, porcelain interiors. Block ice maker with 300 pounds' daily capacity. Cooled drinking water piped to fountains in first and second floor corridors.

**LAUNDRY:** Washer, extractor, tumbler, press, 100 inch ironer, two ironing boards and domestic type of washer for small lots. Acoustical plaster ceiling. Steel glass-lined clothes chute with shower and drain.

**KITCHEN:** Divided into cooking unit and serving unit. Gas ranges, steam table, steamer, bake oven, vegetable peeler, ice cream making and hardening cabinet, glass-lined coffee urns, small gas range for special diets. All work tops, stainless steel. Central tray service. Dietitian's office, glass partition on side facing kitchen.

**DOORS:** Panel-type wood; concealed door closers with three stops.



Second floor: The design of the operating and delivery sections affords efficiency and aseptic protection. Two waiting rooms, furnished with leatherette furniture in colors to match the predominant note in the bright wall paper, are located on this floor. Furniture in the wards is painted metal in tints of green, yellow, blue and pink. Each bed has a cubicle curtain, of green or beige, to ensure privacy. Below: Nurses' dining room located in the basement. Other facilities in the basement include a workshop for carpentry, plumbing and painting; morgue and necropsy rooms; staff dining room; large, well-ventilated meeting room with acoustical ceiling; employees' lockers.



**STORAGE SPACE:** Separate locked storage rooms for housekeeping, medical and nursing departments, medical records, gas and anesthesia, alcohol, food and general supplies and equipment.

**COSTS:** Excluding land, entire cost, including all furnishings, fixed and loose equipment, fees, station wagon, sewage disposal plant, garage, grading, paving, planting and decorating, \$800,000. Cubic content 770,000; cost per cubic foot of hospital building alone, 75 cents. Cost per bed: \$20,000 if computed at 40 beds; \$13,333 if computed at 60 beds or about \$11,000 if computed at 76 beds. Bids taken in November 1940; building opened November 1942.



# Do Normal Maternity Cases Require Ten Days in the Hospital?

**BENJAMIN W. BLACK, M.D.**

MEDICAL DIRECTOR AND SUPERINTENDENT  
HIGHLAND-ALAMEDA COUNTY HOSPITAL  
OAKLAND, CALIF.

**U**NDER present conditions, with the marked shortage of hospital beds, the extremely heavy demands being made upon the already overtaxed facilities for maternal care and with the absence of many physicians serving in the armed forces, the traditional handling of maternity patients is being called into question. An increase in birth rate but accentuates the problem and increases the demand for maternity beds.

The number of convalescent hospital days has of necessity been decreased for practically all types of patients. This has made available additional delivery facilities for a larger number of parturient women. Even with these additional beds, however, other measures must be taken if hospital care is to be extended to meet the demands. Recognition is now given to the requirements of parturition as the chief reason for obstetric hospitalization. It is generally considered that the most critical hours of this period include the time actually required for delivery.

## **Patient's Recovery Not Affected**

Whether this attitude is justified, considering the factors that influence maternal morbidity and mortality, must be determined by a study of the delivery period and that ten day period or longer that follows. Experience in some sections would indicate that if the delivery period is covered by good care in the hospital, an early discharge will not materially influence the patient's recovery.

There can be no question about the importance of meticulous after-care in maternity cases, but our experience at Alameda County Hospitals, Oakland, Calif., after twelve years of following a program of shortened maternal stay in the hospital, indicates that its efficiency need not be impaired by the transfer of normal patients from the hospital to the home at a much earlier date than

custom has decreed. More than 12,000 patients have been handled during this time and the procedure of early discharge has become routine. It is based on the physical condition of the mother and child, a reasonable amount of help and a plan to allow rest at home under minimal medical and nursing supervision.

The accommodations in this public hospital permitted the care of about 600 maternity cases per year, allowing a stay of ten days. With the increasing demands of a decade ago, we were required to handle an additional load of 300 patients annually. By adopting the shortened stay our ability to handle these cases was increased so that we could care for the extra cases per month with the same bed capacity.

It was determined that patients would be primarily received in the hospital for delivery service and that they would be discharged when the condition of mother and child permitted; the earliest day of discharge was on the fourth day. Requirements demanded that reasonable provisions for supervision of after-care in the home be arranged. It was soon found that the mother might be able to return home on an early day but the child should remain because it was underweight or had developed other complications so that a longer stay was required.

Any complications found with the mother, such as excessive flow, slight rise in temperature or symptoms pertaining to beginning lactation, required a longer stay and prohibited an early discharge. Infections, when present, and time required for recovery from operative procedures extended the period of hospital care. After discharge, such professional follow-up services as were required

were continued by the nurse and by the physician, when his services were necessary. Any departure from the normal progressive recovery while at home demanded immediate return of the patient to the hospital to determine the cause of the complication and allow necessary steps to be taken to provide treatment.

At the end of three years, a careful study of the 3400 cases so handled was made. In no case were complications or disease requiring readmission considered to be due to early discharge but rather to superimposed illness or conditions not connected with the maternal period. Since that time, cross-section studies support the original findings and show surprisingly few departures from the normal, probably not a greater number than would be found with any other groups handled under different conditions and with longer hospital stay.

## **Length of Stay Varies**

About one third of the patients were discharged on the fourth day following delivery; about 30 per cent were discharged between the fourth and the eighth day, and about 35 per cent were discharged after the eighth day; some remained as long as twelve or fifteen days, depending upon their hospital needs.

In adopting such a policy, consideration was given to the wide differences in the teaching relative to maternal care by eminent authorities. Williams states in his book: "Every patient should be kept in bed until the fundus of the uterus has disappeared behind the symphysis pubis; generally speaking, two weeks is not excessive." De Lee allows "a normal puerpera, after a normal labor, to sit up in bed on the sixth or seventh day, get out of bed into a large chair on the ninth or tenth day—and before the end of the second week to have the freedom of the floor."



On the other hand, men of prominence, including Charles White of England, who wrote in 1773, Kustner and his associates in Germany, Polak, Galloway and Parker, have all advocated greater activity during the puerperium. Galloway writes that there are certain benefits that can be accomplished if the patient is allowed more activity and permitted to take early, simple exercises while in bed. He even permitted his patients to get around much earlier than the tenth day.

It has been held by some that drainage is facilitated, leading to less likelihood of infection; that better circulation follows, leading to better involution, a tendency toward the prevention of thrombosis and a general improvement of the skeletal muscle tone. Modern, thoughtful trends that now prevail favor a more active puerperium.

Generally, all conditions mentioned concerning good maternal care must be met. The patient should be sent home by suitable conveyance, preferably by ambulance; she should remain in bed until reasonable contraction of the uterus has occurred. Her condition determines when she shall leave her bed and the frequency and length of time permitted. One of the most difficult problems for us to meet did not concern itself with medical or nursing supervision but with finding someone to take care of the other children in the home, prepare their meals, get them off to school, put up the husband's lunch and keep the home in reasonable order.

Relatives, friends and neighbors often assumed these responsibilities, and when this could not be arranged, maids under the Works Progress Administration who had received some instruction in home care of the sick were assigned as need existed. Many of our patients stated that these arrangements under proper supervision of public authority satisfactorily solved their problems.

After this long experience, the discharge of these patients when their condition permits is accepted as a routine procedure. Many of the women are pleased to go home at an earlier date and frequently make the necessary arrangements before admission. Rarely are objections raised and little or no explanation is demanded or sales resistance encountered.

Atlee of Canada reported similar experiences when he reported a large number of women who had had several children and wrote in praise of a more active lying-in period. He states that many of his private patients were able to take up household duties at an earlier

date following discharge and reported no conclusions contrary to ours. It is the considered opinion here of our staff that few, if any, of the cases that have been discharged from the hospital early have suffered either directly or remotely by reason of early discharge.

## In Praise of Commercial Solutions

ROGER W. DeBUSK, M.D.

EXECUTIVE DIRECTOR, EVANSTON HOSPITAL, EVANSTON, ILL.

WE USE commercially prepared solutions at Evanston Hospital for the following reasons:

1. *Responsibility to the Patient.* It is assumed that the hospital is morally obligated to give the best obtainable therapeutic and diagnostic agents, technical and medical staffs to the patient. The question naturally arises as to whether the hospital is in a position to compete with commercial companies in providing a technical staff for the purpose of making solutions.

Certainly, in this day of high turnover and competition with industry, this is an important consideration. Is the hospital able to provide the solutions laboratory with all the material for testing every batch of solutions for pyrogens, anaerobic and aerobic bacteria and chemical purity of water?

2. *Cost.* Although it has been stated in many articles that it is less expensive to make solutions than it is to purchase them we do not believe that this is so in the average sized and small hospital (250 beds or less). We note that opinions to the contrary come from the large institutions. Should we figure the cost of raw materials and labor and add to this the cost of facilities, such as light, heat and power and an increment for space, we find that the cost is higher than anticipated. We also find that space is at a premium in most hospitals.

3. *Legal Responsibilities.* I wonder if the courts, in case of accident and suit, would look with favor on

the hospital that manufactures its own solutions when commercially prepared solutions made by concerns that devote all their time and effort in this direction are available.

4. *Research.* A high percentage of the advances in the use and administration of parenteral solutions has come from commercial companies. We feel that, in some measure at least, we should help support these researches and also be in a position to benefit by the innovations as soon as they are obtainable. It is questionable how long rubber will be available and it is safe to assume that the commercial companies will find a capable substitute, tested and found safe. We doubt that the individual hospital would or could undertake this research.

5. *Multiplicity of Solutions Now in Use.* At the present time we are using the following solutions: normal saline; 5 per cent dextrose in normal saline; 10 per cent dextrose in normal saline; 5 per cent dextrose in isotonic solution of three chlorides (Ringer's); 10 per cent dextrose in Ringer's; 5 per cent dextrose in lactate Ringer's; 10 per cent dextrose in lactate Ringer's; 5 per cent dextrose in distilled water; 10 per cent dextrose in distilled water. In addition, there are available alcohol in saline, vitamins and sulfa drugs in solutions for intravenous use. The future will probably see the development of many more. We question the advisability of making up any but the simple solutions in any event.



# ARMY HOSPITAL

## *Takes to* WHEELS

LT. COL. THOMAS N. PAGE

U. S. ARMY MEDICAL CORPS

LATE in 1939 the surgeon general of the Army, feeling certain that the need for hospital trains would soon arise, directed the planning division of his office to make a study and submit recommendations to him for the development of suitable plans around which to build a modern hospital train. Speed in this planning was urged in order that these trains could be procured as early as possible so that we would not be caught unprepared.

The problem was to design a train that would provide the following accommodations:

1. Berths for a minimum of 60 bed patients.
2. Messing for approximately 360 patients and a train detachment of 43.
3. Space and equipment for emergency treatment.

4. Quarters for train detachment of 43.

5. Seats and berths for approximately 300 walking sick and wounded.

6. Space for baggage and equipment.

7. Office space for train administration.

8. Ease of loading of litter cases.

9. No fewer than 15 cars.

After the necessary study and co-

ordination with the various War Department agencies concerned, it was decided that there should be initially two basic designs. Conferences were then held with the Pullman Company and a 15 car train that afforded the following facilities was developed:

1. Two ward cars to provide space for 64 bed patients.

2. A unit car with kitchen capable of messing 500.

3. A unit car with dressing room completely equipped.

4. Train detachment to be quartered in standard pullmans.

5. Seats and berths for approximately 260 walking sick and wounded to be furnished in standard pullmans.

6. One baggage car for supplies and equipment.

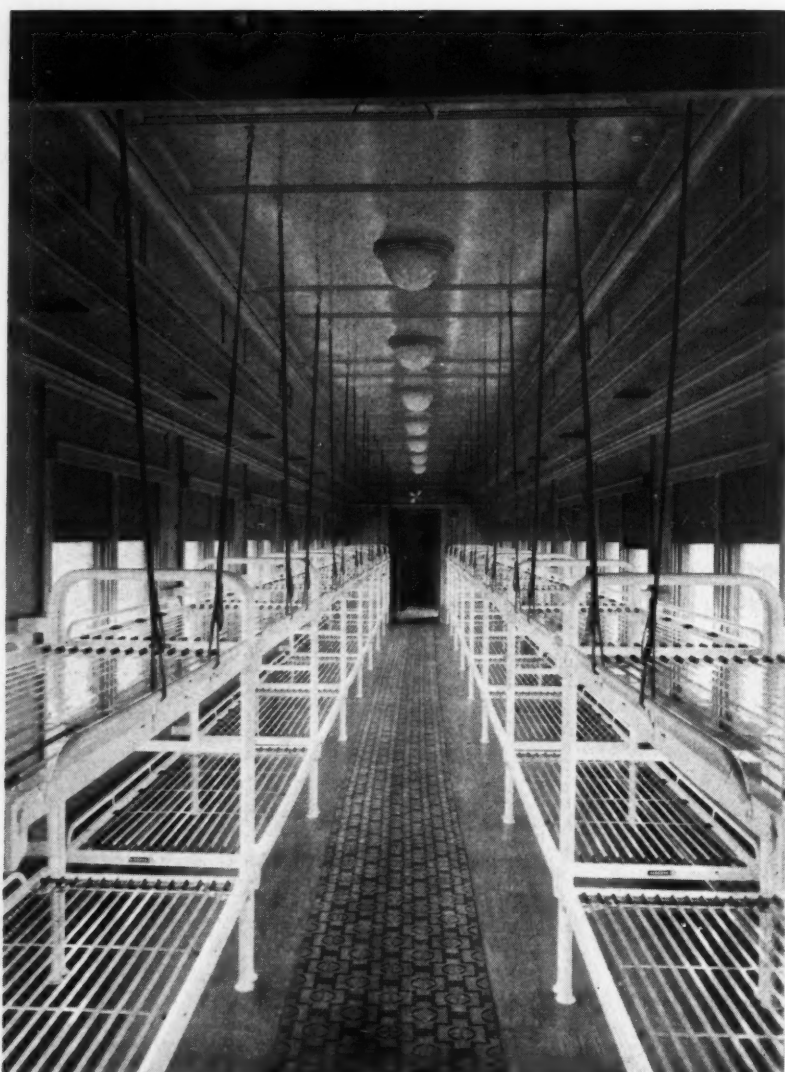
7. A unit car with berth and office space for the train surgeon.

8. Large double doors in both sides of every car at one end for ease in loading litters.

The total train capacity (minimum) is four officers, six nurses, 33 enlisted men and 324 patients.

Early in 1941 the first two hospital trains based upon this plan were put into service and furnished hospital train evacuation for the large scale maneuvers held during the last two years.

A later directive from the surgeon general was issued calling for a re-study of our trains with a view toward simplification, made necessary by a limitation of certain critical materials and need for speed in production. This directive pointed out that standard rolling stock should be



Interior view of the ward car which provides space for 32 patients in double tier bunks.



Hospital unit car No. 2, one of the first of the hospital cars put into service. Photographs from the Army Signal Corps.

Hospital ward car No. 1. Note the double doors at far end of car to facilitate the loading and unloading of stretcher cases.



used with a minimum of conversion.

In conference with railroad officials who had handled hospital trains in World War I, it was decided that standard diners could be used in lieu of the unit car and inquiry revealed that sufficient of these diners could be provided for this purpose. It was also felt desirable to increase the bed patient capacity and still provide space in which to give any emergency treatment necessary.

The new problem was exactly the same as the first except that additional space must be provided for bed patients, bringing the desired minimum to 90. Furthermore, it was necessary to develop substitute facilities for those of the unit car and eliminate all unnecessary equipment and conveniences.

The train that was designed comprised 15 cars including one ward car modified to provide 30 berths for bed patients and a dressing room with complete equipment; two ward cars providing berths for 32 bed patients each; a standard dining car to provide messing for approximately 300 patients; a standard pullman car to quarter the train detachment; a standard pullman car to provide berths and seats for approximately 225 walking sick and wounded pa-

tients; a baggage car for equipment and supplies, and office space for the train surgeon. The same type of double doors are used in the modified ward cars as in the ward car.

Six of these trains were procured by August 1942 and are now in service giving excellent results.

All three types of these cars were converted from standard pullman cars, which are 74 feet, 6 inches overall in length, not including the vestibules at either end. The interior width of the cars is 9 feet, 1 inch. All former equipment was completely removed and the interior was entirely refinished with all special equipment built to the specification of the surgeon general's office.

The unit car provides space for kitchen equipment, dressing room, dispensary, cook's quarters and officers' quarters. The kitchen equipment includes the following:

Ice box of metal construction with ice capacity of 500 pounds, filled from the outside. Its two compart-

ments each measure 27 inches by 31 inches by 7 feet, 5 inches and are equipped with hooks and shelves.

Two standard dining car 6 foot coal burning ranges.

Two hot water tanks of 15 gallon capacity each, a ceiling tank of 400 gallon capacity and an under-floor tank of 220 gallon capacity.

Coal bunker with capacity of 1 ton (two days' operation), filled from outside.

Water filter of the small pressure type for drinking water.

Lockers for miscellaneous articles.

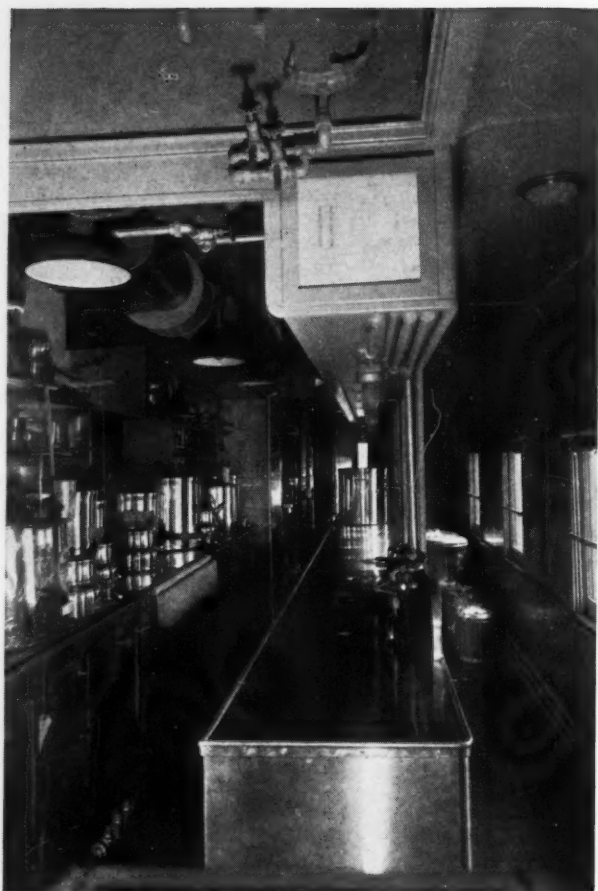
Monel metal serving table equipped with double sink with covers so that it can be used as a preparation table when necessary.

Fans of the outdraft type to remove all odors.

Pots, pans and utensils; all standard Army quartermaster items, including a bread slicer.

The dressing room is completely enclosed with a through passageway outside and to one side of the car.





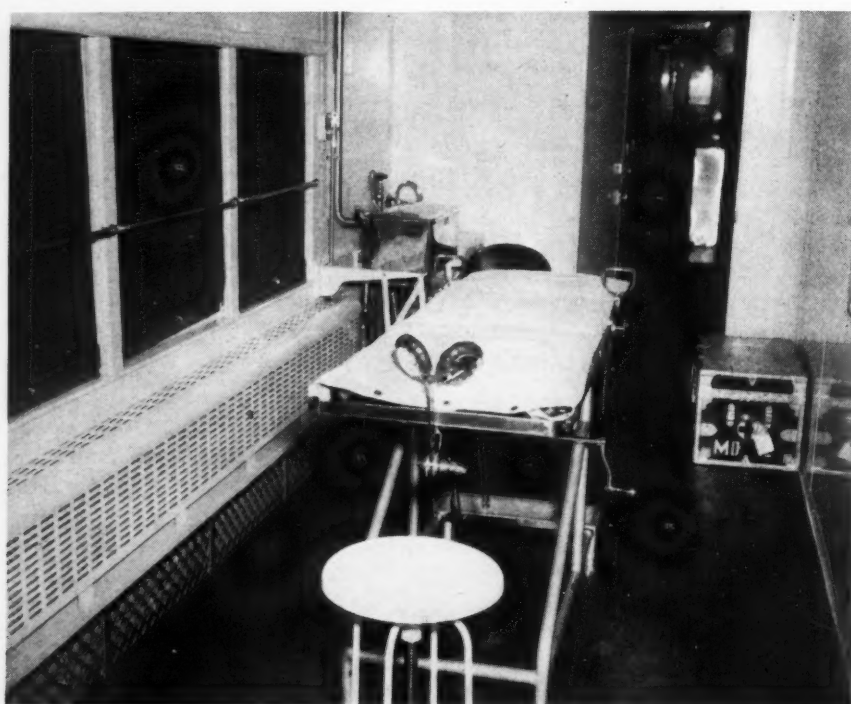
Left: The kitchen equipment includes two 6 foot coal burning ranges, monel metal serving table furnished with a covered double sink that can be used as a preparation table, metal ice box with an ice capacity of 500 pounds and all standard Army quartermaster items. Below: View of the operating room, which is used for emergency operations, daily dressings and examinations.

Doors are large enough to permit the passage of litter cases without difficulty.

A standard medical department instrument cabinet is recessed at one end of the room. The remaining equipment includes an adjustable operating table secured to the floor by turnbuckles; a kerosene operated

instrument sterilizer of sufficient size to handle all necessary instruments; medical department chest No. 2, which contains the miscellaneous supplies necessary for this room, and a scrub sink with foot controls.

The dispensary is stocked with the necessary drugs and equipment for



the care of 360 patients on relatively short runs. These supplies are of necessity limited as to quantity and variety.

The cook's quarters are provided with two double-deck berths, shower bath, toilet, clothes closet and locker, while the officers' quarters are provided with two berths, toilet, wardrobe and office space. This office space contains one field safe and regimental field desk with a small portable typewriter.

A capacity of 32 bed patients in a double tier of bunks has been provided in the ward car. The upper bunk is low enough so that the patient can be easily administered to. Bunks are set away from the wall to afford ease in cleaning and ample room is provided underneath the lower bunks for a standard quartermaster foot locker.

There is ample storage space for all necessary linens for an average run. Bedpan and urinal racks are installed in the service sink compartment, which is capable of being completely shut off from the car.

A large compartment at one end provides facilities for the loading of a standard 90 inch litter. In each side of this compartment are double doors that open inward and are tightly sealed when closed. This compartment also furnishes office space for the nurse on duty and additional storage space for the personal effects of the patients.

The modified ward car is essentially the same as the ward car except that its bed capacity is cut to 30 patients and the loading end is capable of being closed off from the rest of the car to form a dressing room. This emergency dressing room is equipped with a standard field operating table which, when not in use, can be stored to one side out of the way. When in use, it is anchored to the center of the dressing room under two reflector lamps by means of a pair of turnbuckles and floor plates. This room is also equipped with an instrument cabinet, instrument sterilizer and scrub stand with foot pedal control.

Attention should be called to the fact that these trains are for use in the zone of the interior only and not in the communications' zone. Trains for the communications' zones must be made up in their entirety and be able to run on the various railroads encountered.

# Essentials for a Urology Service

JAMES W. HUBLY, M.D.

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TODAY the office practice of urology is becoming secondary to hospital practice. The urologist is dependent upon the hospital for the special services necessary to effect proper care of the patient.

Urology has made great progress, especially in the last decade. Contributing factors in the progress made have been the perfection of special instruments, particularly those used in transurethral surgery, the advent of the sulfa drugs, the improvement in postgraduate urologic training and the development of departments of urology in the hospitals.

The specialty may be divided into diagnostic, medical and surgical urology. Diagnostic urology includes cystoscopy, pyelography, urography and laboratory diagnosis. Medical urology concerns itself with the therapy of the nonsurgical lesions. Surgical urology includes all surgery of the genito-urinary tract wherein transurethral surgery is an important subdivision.

## Staff Cooperation Is Essential

In an ideally organized hospital the department of urology should be headed by a urologist certified by the American Board of Urology. He is responsible directly to the chief of the surgical staff of the hospital. No urologic service will function at maximum efficiency without complete cooperation among the staff members of the service, the chiefs of surgical and urologic services and the hospital administrator. A liaison officer elected from the urologic staff to act between the staff and the hospital board of trustees is desirable. This contributes to better understanding and often leads to the solution of apparently insuperable problems.

The training of the resident and intern staff is a direct responsibility of not only the chief of the urologic service but every member of the urologic staff. In the average nonteaching hospital the resident and the in-

tern receive a rather informal type of instruction. I should like to suggest that to the daily pyelogram and urogram clinic, the weekly staff conference and the monthly clinical pathological conference a weekly evening seminar be added. This seminar during a year ought to accomplish a thorough review of the subject of urology, particular emphasis being placed upon collateral reading of current journals.

The superintendent of nurses must direct the urologic training of the student and graduate nurse. In a hospital possessing a urologic service the training of the student nurse is a matter of routine. The graduate nurse who works with urologic patients requires special postgraduate education. This is particularly true of the male nurse who finds his most useful niche in the care of urologic patients. A program of instruction outlined by the chief of the urologic staff and implemented by the superintendent of nurses will do much to promote intelligent skilled nursing.

The accommodations that a department of urology will require in a hospital depend entirely upon the number of patients it must serve. Generally, it is best to keep the department as compact as possible. It should be adjacent to the x-ray department or have complete x-ray facilities of its own, including a darkroom. The latter is important and often forgotten. Pyelograms and urograms should be developed and viewed before the patient leaves the cystoscopic table. Roentgenograms that will not permit adequate diagnostic interpretation are discovered in this way and are retaken. This obviates a second examination of the patient. The only satisfactory way of accomplishing this is to have a darkroom immediately accessible.

An excellent combination is to have the cystoscopic rooms, x-ray and

surgery on the same floor. This arrangement not only is satisfactory for the diagnostic service but is a valuable contribution to surgical urology. For example, a roentgenogram taken at the operating table during a nephrolithotomy to check the position of a stone or to determine if all fragments are recovered is a distinct help to the surgeon if it can be developed and viewed immediately.

## Urology Laboratory Valuable

A conveniently accessible urologic laboratory is desirable. It need not be elaborately equipped but should include facilities for adequately examining urine and smears. These include a high speed centrifuge, a microscope, slides and cover slips, the acid fast and Gram's stains, an ice box and culture media.

This laboratory is in no way to be confused with the general hospital laboratory. It is for the use of the resident and intern staff and for the urologic staff members. It promotes the education of the resident staff and avoids delay in obtaining reports.

This operates to the distinct advantage of the patient. For example, a male patient on a urologic service has a suspected urinary tract infection. A two-glass test is made. The urine is sedimented. The wet smears are examined. The dried smears are stained with Gram's stain and the diagnosis is confirmed in perhaps ten minutes. Treatment can be intelligently instituted at once without the delay that necessarily occurs when specimens are routed through the general hospital laboratory on any other than "stat" orders.

It is best to group all urologic patients in one wing or one floor of the hospital. One or several urologic examining and treatment rooms, depending on the needs of the service, may be located adjacent to this area, and the laboratory will likewise be conveniently accessible. This encourages better training of resident and nursing personnel and with such

From a paper presented at the Tri-State Hospital Assembly, Chicago, May 1942.



specially trained personnel the patient service improves markedly.

It is true that grouping special services in various areas of the hospital limits to some extent the available hospital accommodations from which the patient may choose. However, I should like to remind the hospital administrator that the hospital is not a hotel. It is a place to which the sick come to get well. If the urologic patient can get well faster, and I think he can, by the simple expedient of being placed in a certain area of the hospital where he will receive specialized care, then that procedure should be encouraged. In hospitals that have strict rules in this respect there is little difficulty in hospitalizing patients in their respective areas. Especially is it so when they understand the benefit that accrues to them.

All urologic equipment should be kept in a central urologic supply room and not scattered throughout the hospital. This is practical only if all urologic patients occupy one area of the hospital. The supply room must contain all facilities for the sterilization and maintenance of urologic equipment. The urologic dressing carts are serviced and operated from this room. Catheterization trays should be dispensed from this supply room. The supervising nurse in charge of the supply room is best suited for her work if she is a graduate surgical nurse with special postgraduate training in urology.

#### **Mayo Clinic Forms Satisfactory**

I approach the matter of records with some hesitancy. Most hospitals have uniform general history and examination forms but their cystoscopic and medical urologic record forms differ greatly. A general criticism of the average form is that for statistical studies and for teaching purposes it lacks detail. The Mayo Clinic forms are quite satisfactory and I have not had occasion to modify them. The cystoscopic form is fairly complete and is filled out by underlining the positive findings. This eliminates dictation, an economy most hospital administrators will approve.

Another form is used for the reports of pyelograms and urograms, for kidney function tests, for cultures and stains, for guinea pig inoculations and for microscopic urinalysis so that finally there is gathered to-

gether on one form all of the necessary information for making a diagnosis. A medical urologic form is useful as a consultant's record. It in no way supplants the general history and examination record.

Recently I had the opportunity of observing the urologic services of a representative group of hospitals in southern Michigan. The counterpart of this area can easily be found in other states. Certain facts were brought out that may be of interest here.

First, there is the problem of the small community of from 10,000 to 20,000 population with a hospital of 50 beds. That hospital cannot ordinarily expect to develop a urologic service. Second, the community ranging from 50,000 to 100,000 population with one or more hospitals varying from 100 to 300 beds more often than not lacks a urologic service. Here is a specific example of failure by the hospital administration and medical staff to further community service. Finally, there are the large hospitals in metropolitan areas. Not all of these hospitals have urologic services but when present they are for the most part well planned and they function efficiently.

It is apparent that the greatest opportunity for developing or improving urologic hospital services lies in the medium sized community. No elaborate survey is necessary to determine the fundamental factors that interfere with this development. They are:

1. Interhospital competition and duplication of clinical services. The average community usually supports two general hospitals. Ordinarily, the medical staffs of the hospitals are identical. All clinical departments are duplicated. A certain degree of competition customarily exists between the administrative organizations of the two hospitals and this rivalry tends to filter down into the medical staffs so that certain doctors not unnaturally show a preference for one or the other of the hospitals.

This type of rivalry fosters the continued duplication of clinical services and, thus, prevents hospital specialization in specific departments. When the hospitals of a given community are viewed in the light of community need it becomes clear that duplication of clinical services is inefficient and uneconomical and fails to

benefit the patient. The hospitals and their various clinical departments should be regarded as parts of an efficient integrated hospital system serving a given area.

To duplicate urologic services for reasons of hospital prestige and rivalry is of no help to the community, especially when the establishment of that service in one hospital would benefit the patient, the hospital and the doctor. To break up this wasteful duplication it will be necessary for the hospital administrators to do some good old-fashioned American horse trading—pediatrics for urology, for example.

#### **Hospital Should Furnish Equipment**

2. Failure of the hospital to furnish equipment. This necessitates physician-ownership of equipment, a practice inherited from our grandfathers and one that should be condemned. It causes unnecessary duplication of equipment and is wasteful, an important consideration in war time. It acts to the distinct disadvantage of the patient.

For example, a urologist is performing a routine cystoscopy under intravenous anesthesia. He finds a stone in the bladder and would like to remove it immediately. However, his lithotrite is not available. It is perhaps in his office or in his instrument case in the other hospital. In any case he does not have it at hand and the hospital cannot supply it. So for want of an available instrument, what might have been done with one surgical procedure requires two. In hospitals that supply equipment this sort of thing does not occur.

3. Lack of an adequately trained urologist to head the service. The actual practice of urology in the hospital that lacks a urologist certified in his specialty may be entirely in the hands of the general surgeon. Here the absence of a properly trained specialist prevents the development of the service.

This deficiency can be solved in one of two ways: A member of the surgical staff may be persuaded to go away for postgraduate training which will allow him to receive certification by the American Board of Urology or an already certified urologist, given encouragement by the medical staff and hospital administrator, may find it to his advantage to establish practice in the community.



# Motion Pictures Project

## HEALTH

*Educational films teach clinic patients at Mount Zion Hospital to prevent disease and improve health and living conditions*

**J. A. KATZIVE, M.D.**

DIRECTOR, MOUNT ZION HOSPITAL  
SAN FRANCISCO

THROUGH the generosity of one of the members of the board of directors, a 16 mm. sound motion picture projector and screen was made available to the out-patient department of Mount Zion Hospital, San Francisco, for the purpose of providing health educational opportunities for clinic patients. The educational program includes motion picture films touching on the subjects of personal hygiene, first aid, care of the patient in the home and other public health matters, such as diet, sanitation and control of communicable diseases.

These films are shown in the common waiting room for patients who are waiting to be called to their respective clinics, for prescriptions to be completed, for relatives, for future appointments or for social service consultation. For the most part the films are of the silent variety so that the physicians and patients in the clinics are not disturbed.

In order to avoid the possibility of showing the same films to the same patients the program is varied to conform with the scheduled clinic days. Saturday showings are arranged primarily to interest children who attend in greater numbers on this day.

### Films Hold Children's Interest

We anticipated considerable difficulty in the beginning as it was felt that the clinic routine would be greatly disturbed, the medical staff would be distracted and the children would become unmanageable. However, we were pleasantly surprised to notice exactly the opposite effect. The children who heretofore would not stay quiet became deeply interested in the films and the continuous hum of voices resulting from numerous conversations was hushed.

The patients themselves have shown an unexpected interest in the program and to many it has provided a source of inspiration to improve their own living conditions and health facilities. Many of our patients have spontaneously commented favorably, leading us to believe that the expense of the program is more than justified. All films are previewed before showing so that, if necessary, objectionable films could be omitted or restricted.

Although this program was not prompted by present war conditions, it has been a means of educating civilians in the care of themselves and members of their families in the home. By virtue of this education, they have become less dependent upon public health nurses and other public health and social agencies, thus relieving them for other urgent civilian defense activities. Several of our films, particularly those dealing with first aid, have been made available to the Red Cross first aid and nurses' aide training programs. In a broader sense the films aid the defense program by teaching our citizens ways and means of preventing disease and maintaining and improving their health.

It has proved a valuable adjunct in the well baby clinic in teaching mothers the proper care of the child. Our metabolic clinic has also found these films of considerable assistance in the proper selection and evaluation of foods required in prescribed diets.

The projector is operated by a Red Cross Gray Lady as a part of a recreational therapy program and also as part of civilian defense work. The films are self-explanatory for the most part, but when additional comments are needed the head of the department concerned may comment.

Incidentally, this equipment is also available for other parts of the hospital when not used in the out-patient department. The medical staff has found it advantageous in

presenting medical programs and the school of nursing has employed it in the instruction of student nurses in proper procedures and for general instructions in medical care.

As time goes on, we shall probably find many other useful applications, such as instructing our women's auxiliary in the work of the hospital and educating the public in the part the hospital plays in the community health program on National Hospital Day and other occasions.

### New Film Sources Developed

Our out-patient department supervisor has been keenly interested in this program and has given it impetus. Through her continuous and diligent search for new sources of educational films we are gradually building up a library of those which we feel are of lasting interest and which can be shown repeatedly over long periods of time.

We have also been able to compile the following list of distributors whom we call upon for the purchase and rental of films listed in their catalogs or in other listings published by Film Information Service, Hearst Tower Building, Baltimore.

*Personal Hygiene:* "Keeping the Hair Clean"; "Cleanliness—Bathing"; "The Feet"; "Posture" (Eastman Kodak Company), and "Life of a Healthy Child" (Bell and Howell Company).

*First Aid:* "Care of Minor Wounds"; "Carrying the Injured," and "Control of Bleeding" (Eastman Kodak Company).

*Care of the Patient in the Home:* "Bed Bath"; "Routine Procedure";

"Special Procedure"; "Bathing the Infant"; "Feeding the Infant" (Eastman Kodak Company), and "Fun in Food" (Contemporary Film Company, San Francisco).

The following films were borrowed:

*Personal Hygiene*: "Bobby's Bad Molar"; "Told by a Tooth"; "Road to Health and Happiness"; "Ask Your Dentist" (San Francisco Dental Society); "Preventing Blindness";

"Sight Saving" (Riggs Optical Company, San Francisco), and "Red-head" (Cereals Soap Company, New York City).

*Care of the Patient in the Home*: "Judy's Diary"; "Play's the Thing" (Children's Bureau, U. S. Department of Labor, Washington); "Proof of the Pudding" (Metropolitan Life Insurance Company, San Francisco), and "Dental Films" (California State Department of Health.

## Black Outside, Light Inside

WILLIAM W. LEAKE, M.D.

Chief Surgeon, Illinois Central Hospital, Chicago

SHOULD a city be subjected to air raids the hospitals must be prepared to carry on their services uninterruptedly and still observe the blackout regulations that are necessary for the safety of patients and personnel.

At Illinois Central Hospital, Chicago, numerous methods of blacking out the institution while still continuing service in the operating rooms, delivery rooms and out-patient department were investigated before a selection was made. The hospital has three general op-

erating rooms with skylights and either one or two sides enclosed with glass to permit the maximum amount of natural light. From information obtained of the hospitals' experience in bombing raids in England, we learned that the greatest danger and the most serious accidents were the result of shattering glass resulting from concussions. Therefore, we were confronted with a serious problem of protecting patients and personnel in the operating rooms in the event of an air raid.

After considerable research, we

found that the most suitable material for this purpose was a rubber adhesive that is applied on both sides of window panes. A test was made by covering the glass on both sides with the material and then subjecting it to seven direct hits, using an ordinary ivory billiard ball. While the glass was shattered as a result of the direct trauma, the adhesive remained in place and no splinters were dislodged.

The adhesive is waterproof and weather resistant with a dull black surface that will not create a reflection. A special white-coated adhesive, which has a pleasing appearance and is washable, was made for use on the inside of the windows of the operating rooms.

The remainder of the operating unit has been completely equipped with black shadowproof shades that extend from 6 inches above the window to 6 inches below the sill and are securely hooked in place. These shades also extend 4 inches on each side of the outer window frames. Similar arrangements were made in the two emergency surgical rooms, the general waiting room in the out-patient department and in six surgeons' consultation offices.

Our electrician and chief engineer have devised a system for the rearrangement of electric wiring that can be completely controlled from the engine room. Upon receiving the warning signal the engineer will allow one minute for drawing shades and will then proceed to pull nine switches. This will completely black out the institution and yet permit the use of the usual lighting facilities in the operating rooms, emergency surgical rooms, delivery rooms, nurseries and out-patient department.

The corridors, elevators and some stairways will have regulation red lamps to permit safe travel without light leakage.

In the event of failure of the commercial electric service, two portable battery-operated spotlights have been provided for use in the operating or delivery rooms. These portable units are made up of two spotlights and two batteries built on portable lighting fixtures on casters, which were designed and built by our electrician.

In addition, an adequate supply of flashlights with regulation red bulbs is available for use of nurses and physicians in carrying on their regular duties.



Shatterproofing material protects patients and personnel from flying glass in the event of air attack. The adhesive material is applied to both the inside and outside of windows. The dull black surface of the material eliminates the hazard of reflection from the glass. A white, washable coating on the inside surface lightens the room and presents a pleasing appearance.

# Calling All

## OPERATORS

**To "listen in" on some sound advice as to the proper methods of handling the hospital switchboard to ensure promptness, efficiency and courtesy in the telephone service**

THE nerve center of the hospital is its communication system. The switchboard operator is the hospital hostess. Upon her cheerfulness, efficiency and accuracy may depend the immediate success or failure of the institution in its relationship to the public.

The operator is in a place of business in which quiet and uniform orderly conduct are essential. She must conduct herself with a degree of pride proportionate to the great responsibility and faith that have been placed in her.

The telephone company judges service by observing on the trunks. Demerits are given the service when the attendant fails to answer properly, is discourteous in words or tone, fails to make proper disposition of a call, is inefficient in taking orders or bungles the mechanics of the board.

The operator's golden rule might be: speak in a soft pleasant tone of voice, clearly and distinctly, without haste or impatience. Be courteous at all times. It makes the job easier and promotes pleasant relations with the persons to whom she speaks.

The voice is carried most clearly when one speaks directly into the mouthpiece with the lips not more than half an inch away. If this direction is changed or the distance is widened some of the sound that ought to reach the listener will stray elsewhere. No shouting or loud talking should be necessary. The transmitter is made to carry words spoken no louder than in ordinary conversation.

When acknowledging an order received the operator should listen closely to the directions and repeat any part of them she does not understand. When the detail is corrected, it should be acknowledged with a

### G. RUSH WILLET

TELEPHONE ENGINEER, CHICAGO

simple "thank you." If the order has been understood correctly, "thank you" is the only acknowledgment necessary.

If it is necessary to determine who is being called, the attendant should say "I will connect you with the Information Desk," or—if the order was indefinite—"Mr. J. F. Smith is the engineer; I will connect you with him."

If the extension is busy frequent attempts should be made to connect the call by testing with another cord pair. On calls that are delayed, it is

**DON'T**—Chew gum while on duty.

**DON'T**—Stick a lead pencil in the jacks on the face of the board or in any way mar or injure the equipment.

**DON'T**—Bring food or liquors near the key shelf.

**DON'T**—Express an opinion to telephone users; if flippant or irate callers are encountered, refer the call to your supervisor.

**DON'T**—Question the attendant adjacent to you.

**DON'T**—Talk out loud at the switchboard.

**DON'T**—Let your voice show annoyance. Remember that your voice is your only contact with the hospital personnel and the people who call in.

**DON'T**—Smoke at the board.

**DON'T**—Listen in on a connection any longer than is necessary to verify the call.

**DON'T**—Forget that a great deal of confidence, faith and trust is placed in you.

important to give progress reports to the calling party at frequent intervals. The calling party cannot hear the operator ring on an extension, and progress reports are required not only as an act of courtesy but also as encouragement to wait long enough to provide opportunity for the called party to answer.

A progress report should be given as soon after establishing the connection as possible and about every thirty seconds thereafter. "Mr. Smith's extension is still busy. Will you wait longer?" or, in the case of a slow answer, "I am ringing Mr. Smith for you," are the preferred phrases to use in giving a report. If no response is received to a progress report and it appears that the calling party has hung up, the report should be followed with, "Are you waiting?" If no answer is received, the line can be disconnected immediately.

When a connection is established after a delay, the operator should cut in on the line to be sure the party is still waiting and say, "Thank you for waiting; you may have Mr. Smith now."

**DO**—Be courteous and helpful to the people you serve and to your fellow workers.

**DO**—Sit up straight in your chair; form the habit of good posture.

**DO**—Speak in a low tone, using just enough volume to be heard clearly through your transmitter.

**DO**—Watch your schedule carefully and be on time; punctuality is a habit.

**DO**—Make every effort to be cooperative.

**DO**—Learn to enjoy your work, for there is a real satisfaction in doing a good job.

**DO**—Make suggestions for improving the service, but only after you thoroughly understand all phases of the problem.

**DO**—Take care of your share of the work to the best of your ability; learn accuracy first.

**DO**—Remember—you are a momentary host to the people whom you greet at the telephone door. Your mannerisms are the hospital's mannerisms; therefore, speak at all times as you would be spoken to.



# *Let's Apply* PSYCHOLOGY

## *In Selecting Employees*

LEROY N. VERNON

DIRECTOR, PERSONNEL LABORATORY, CHICAGO

**N**OT enough attention has been given to the selection of employees in hospitals. As standards of professional training have been raised, there has been a tendency to lose sight of certain aspects of an employee's suitability for his job that are not adequately reflected by degrees and diplomas.

Successful operation of a hospital requires intelligent handling of public relations and industrial relations in addition to a high standard of technologic performance, and it is in the field of industrial and public relations that improvements need to be made.

### **Personality Must Be Considered**

In the selection of an employee the question of his personality or of his effect on other people needs to be considered along with his professional training. In the appraisal of the intangible qualities that determine an individual's effectiveness with other people, administrators could put to good use certain psychologic technics that are already being widely used in industrial organizations in the present emergency.

In a hospital the factor of morale of employees is especially important. An institution comes to have a prevailing atmosphere almost like the personality of an individual, and visitors or patients are immediately aware of tension, anxiety, antagonism and avoidance of responsibility or of poise, confidence and friendliness.

While morale is to some extent dependent upon wages and working conditions, probably the most important factor is the kind of people who make up the group. There are qualities of mind and of spirit that

make any individual definitely undesirable as a hospital employee and industrial psychologists today are learning how to define and measure some of these qualities and to predict in advance of hiring what kind of influence any given individual will have on the organization.

Psychologic testing may be thought of as an extension of the personal history and the employment interview, for the tests that contribute most to the improvement of employee selection are really standardized questionnaires that ask questions of the same type generally used in employment interviews. They produce more reliable results because they are not dependent upon the faulty memory and the personal likes and dislikes (which we all have) of some individual interviewer.

In the employment situation personality tests are much more promising at the present time than the so-called aptitude tests, and something constructive might be done with hospital personnel in the measurement of personality traits.

Personality traits are for the most part patterns of habits and include the common neurotic tendencies, attitudes and habits of personal emotional life and of social intercourse. Although these habits change, they are remarkably stable in most adults and predictions about an employee's behavior based on his answers to questions concerning his habits and attitudes prove to be accurate enough for practical purposes.

For instance, there is the habit of approaching other people in a "promotional" frame of mind. We might call it aggressiveness, dominance, ascendancy or even sales personality. By whatever name it is known, this

quality is a stable characteristic of an individual at any given time, and it is a characteristic in which individuals differ radically from one another.

An extremely dominant person makes a good salesman but not a good supervisor. A person who is unusually deficient in dominance can do neither kind of work well and is better suited to technical work that does not involve contact with other people.

### **Supervisors Need Self-Sufficiency**

Another characteristic that can be measured with considerable reliability has been called "self-sufficiency." The self-sufficient person is more or less what William James would have called a "tough minded" person. He is highly independent and may lack dominance, not because he hesitates or is afraid of other people but because he feels no need to assert himself with them. He is a person who would be described as decisive, willful, independent and resistive to the suggestions of others.

Self-sufficiency is a necessary quality in a person who is to carry supervisory responsibility. These two qualities of personality, dominance and self-sufficiency, go a long way toward describing variations among people that are referred to by many other descriptive words.

A third characteristic that makes a world of difference in any employee's value to his organization would in ordinary language be called selfishness. The selfish person who seeks his own advantage in every situation and who usually has a short-sighted view of his own advantage is contrasted in this charac-

*Training alone does not qualify an individual for his job. Those personality quirks that determine his ability to get along with other people must be taken into consideration, too*

teristic with the one who has the habit of being generous to other individuals and of being loyal in his relations to organizations and to persons. The capacity for loyalty and generosity differs widely from person to person. It probably is a result of one's idea of himself or of his "rôle," and because it is part of his rôle a person reveals himself on a questionnaire to a much greater extent than one would expect.

The fact that every person has a rôle is the reason why personality inventories can be made to yield practical results. Every person has a certain concept of himself which he rationalizes in his own thinking and about which he feels a certain pride. This is his rôle. Even though it is a selfish one and quite lacking in generosity or loyalty, still he will present the facts about it with little evasion or equivocation. He has justified it to himself and because he has justified it he will describe it and himself with a frankness that never ceases to amaze those who work with these technics.

#### Capacity for Cooperation Varies

Another variable can be described satisfactorily in nontechnical language as the ability to "give and take" in social relationships. At one extreme of this quality we have the perfectionist who must do everything he does exactly right and who is always able to rationalize his way into believing that he has done things right in every situation.

He would be described as lacking in open-mindedness, as sensitive to criticism, critical of others and as a generally cantankerous person. His capacity for cooperation is limited. Probably "cooperation" is as good a word as any for this variable. Lack of this ability is bad in any employee but it is a most serious flaw in a supervisor.

Finally, there is such a thing as self-control or, more technically, emotional stability. One individual will fluctuate between moods of elation and fits of the blues and from day to day his mental life will be charged with many shades and intensities of emotional color. Such a person is generally deficient in self-discipline and he is likely to spend a great deal of his time in self-analysis, worry and other forms of ineffectual thinking.

A person who is better adjusted emotionally builds up habits of translating his feelings into definite purposes and of denying himself the luxury of a supercharged emotional life. Measurements of neurotic tendencies are usually no more than measurements of the amount of emotional life the individual reports, and the variable in question might reasonably be referred to as neurotic tendency, emotional stability or self-control.

Here, then, are five personality traits that have a known relationship to the usefulness of employees and can be measured with a satisfactory degree of accuracy and reliability prior to employment: dominance, self-sufficiency, unselfishness, cooperation and emotional stability.

When managers come to think in terms of variables like these, there is an inevitable improvement in the quality of employment interviewing and of the interviewer's judgment of people. A still greater improvement can be effected through the use of standardized inventories that measure these variables.

The mechanics of giving tests of this kind and of scoring and interpreting the results is the greatest impediment to their widespread acceptance. Although the tests are self-explanatory and require no specialized training to administer, scoring and interpretation are another

matter.\* The step from a test score to its meaning in a particular situation is large and calls for a professional background. When several scores are derived for the same individual (as they usually can be derived from a set of answers), they constitute a kind of clinical picture that requires the attention of a trained psychologist.

Industrial organizations with large numbers of employees are increasingly resorting to the employment of psychologists as members of their personnel departments. Enough psychologists have gone into this kind of work in recent years so that a new association called the American Association of Applied Psychology has been formed as distinct from the American Psychological Association. However, one of the advantages of personality inventories is that in an organization that is not large enough to employ a full-time man for this work, the inventories can be administered in the personnel department and sent for scoring and interpretation to an independent practitioner in this field.

#### Hospitals Could Profit by Tests

There is need for further development along these lines and institutions that are conscious of the problem of industrial and public relations ought to make provision in their budgets for doing some of this work. Most of the technics now available are the result of research financed by the personnel departments of large companies and have been done either in universities or by consulting psychologists. However, available technics do little more than scratch the surface of what needs to be done.

Applied research of this kind can generally be made to yield tangible and practical results in operating efficiency and, at the same time, develop new tools with which to solve future problems. It is to be hoped that when institutions and associations adopt the technics now available, they will feel some responsibility for supporting further research.

\*Widely used tests at the present time include the following: "The Personality Inventory" by Robert Bernreuter; "Humm-Wadsworth Temperament Scale"; "Otis Self-Administering Tests of Mental Ability," and "Vocational Interest Blank" by Edward K. Strong Jr. For use in employment situations we have had most success with adaptations of these and other tests worked out in our laboratory and standardized through use in industry.



ADMINISTRATION BLOCK DESTROYED APRIL 1941

**G**UY'S HOSPITAL in common with most London hospitals took its quota of casualties during the period when London was the target for the German air force. It was in the area that suffered most heavily from the onset of the attack in September 1940 until the last great attack in May 1941.

So numerous were the hits sustained and so many were the occasions on which only the work of the hospital fire and repair squads kept the hospital services functioning that it was decided that a record should be kept of all incidents involving the hospital. A room was also set aside for collecting and storing mementoes both instructive and of interest.

This room is quite small and one side is almost covered by a large colored chart of the hospital build-

ings showing where hits by high explosive and incendiary bombs occurred. This, in turn, is flanked by large casualty graphs and such things as remnants of mine parachutes, incendiary sticks, bomb splintered beds, sections from fractured beams and photographs of the old wing of the hospital now unhappily destroyed.

Among the more "picturesque" incidents recorded in the log was an attack that occurred in December 1940.

The log reads: "December—. Incident: High explosive and incendiary bombs." What happened was this: The alert was given at about 19:10, the spotters and fire squads went to their usual posts and within a few minutes a shower of incendiaries fell on the hospital buildings. Twenty or more of these

# GUY'S HOSPITAL Reports an INCIDENT

**B. LEES READ, A.C.A., F.H.A.**

**and NELSON BURGESS**

RESPECTIVELY, CLERK TO THE GOVERNORS  
AND MEMBER, ENGINEERING STAFF  
GUY'S HOSPITAL, LONDON

had been dealt with—some were in almost inaccessible positions—when a stick of high explosive bombs fell across the hospital. The first bomb struck Evelyn Ward in the surgical block, which is in the original Guy's House built in 1724.

Some years earlier a concrete floor had been superimposed on a part of the third floor to enable a row of modern theaters and preparation rooms to be built, and a bare 2½ feet of this concrete protruded under the wooden flooring into Evelyn Ward. The bomb penetrated the roof, cutting through a heavy beam in its path, and then providentially struck this, the only piece of concrete in the ward, which was sufficient to slow up the bomb and cause it to detonate on the second floor.

Had this not happened it would easily have penetrated to Dorcas Ward on the ground floor, which was full of patients. The shock of the explosion blasted the southwest walls of Evelyn and Naaman wards and the debris fell out into the quadrangle. Part of the destroyed upper floors fell on Dorcas Ward, but the ancient beams, although taking the weight of an enormous load of debris, stood up to the strain. The ward was filled with the dust from shattered brickwork and plaster.



The explosion of the bomb not more than 25 feet above the ward had subjected every patient to a severe shaking, yet there was no sign of panic; the patients obeyed every order and waited their turn to be carried to safety. The various hospital squads all joined in the work of rescue and the patients were evacuated to the basement of the medical building in a few minutes.

The next bomb of the stick missed the buildings but struck the roadway outside the hospital linen stores. It penetrated the road and burst in a subway that runs under the buildings. The effect of the bomb blast in the confined space was to convert its energy into a tamped explosion, and the damage was consequently severe. The subway being strongly built, the blast rushed along its length destroying everything in its path. The walls of a basement room 40 feet from the explosion were blown in, burying under the debris four people sitting in the room. Striking the ceiling of the room, the blast forced upward the floor of the ward above. Beds were hurled about and a heavy piano was thrown into the air. Minor damage was done to ward equipment but no patients were injured.

Again, as in the previous incident, the patients remained calm and were rapidly removed to safety. The subway in which the explosion occurred led to the massage department and the nurses' home, and halfway along its length was a little room which



MAJOR OPERATION ON A SURGICAL WARD



DEEP THERAPY DEPARTMENT DEMOLISHED IN DECEMBER

served as a distribution room for all the electric mains feeding that section of the building; the gas and steam mains also ran through the room.

Subjected to the enormous pressure of the blast, the walls of the room collapsed, dragging with them the cantilevers holding the electric mains, and to add to this confusion the steam, gas and water mains also were fractured. The fire and repair squads, which had already done yeoman service in dealing with incendiaries and the evacuation of patients, were now called upon to rescue the people who were trapped in the basement and, in spite of the conditions existing in the subway, managed to do so in a short time.

While this operation was in progress, a most peculiar thing happened!

The electric mains in the distribution room—now invisible in whirling steam and resting in water—instead of putting out the feeding breakers, *i.e.* fuses, in the engine room did exactly the opposite; they shorted through the water and began to feed a dead main. This main supplied the outside lighting circuit of the hospital, and now the strange sight was witnessed of the hospital gateways and roadway brilliantly illuminated during a fierce air raid. By means of bricks or anything else sufficiently heavy, the lamps were soon extinguished by the amazed staff.

It was at this stage that an urgent call was received from the nurses' home, where the roof was found to be on fire in three places. All the men who could be spared were now sent to this fresh incident and after a hard struggle, in which they were assisted by the Sisters and nurses, the fires were brought under control. Hardly had this been done when a fresh outbreak was observed in Doyle's House, a small building used as an overflow dormitory. All water mains were empty by this time so a bucket chain was started and, again with the invaluable assistance of the nursing staff, this fire, in turn, was controlled.

So great was the amount of work thrown upon the fire and repair squads by the almost constant rain

of incendiaries that every available person, with the exception of the nurses and dressers on duty in the wards and casualty reception rooms, was engaged in fire fighting; and so efficient was their work that after two hours had elapsed all fires were under control.

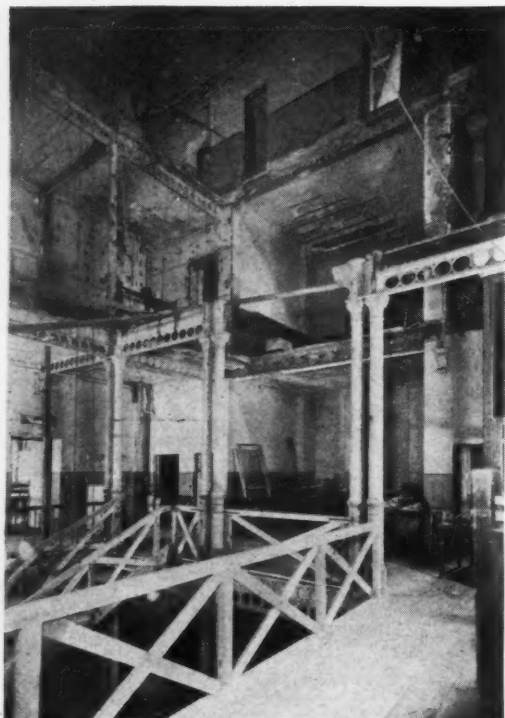
During this period the staff had been so busy in the hospital that it had had no time to worry about the neighbors; it was then realized that the people in the warehouses surrounding the hospital had not been so successful in firefighting and the hospital was surrounded by a sea of flame. The whole district appeared to be on fire and the staff could only look on in helpless amazement while houses and warehouses surrounding the hospital burned themselves to the ground.

Suddenly the wind changed and the hospital faced its greatest danger—fanned by the wind, the fires increased in size and showers of burning material fell upon the hospital. The medical building faced on to a row of burning warehouses and a constant rain of burning debris from the fires now began to pile up in the gutters and roofs. In spite of the scorching heat and suffocating smoke, the staff continued to fight its one-sided battle, and by means of stirrup pumps and extinguishers each separate fire was kept in check except on the roof on one side of the deep

x-ray department which was almost inaccessible; here the flames gradually took hold.

A last effort was now made and a bucket chain was formed over a length of 200 feet and then 75 feet up a staircase. By this means, the fire, although gradually consuming the deep x-ray department, was kept under control and did not become a major conflagration. Whilst engaged in the struggle the student members of the fire party could see their own quarters in the college a few yards away from the hospital being destroyed. A few men were detailed to salvage valuable personal belongings, which were dumped in a basement corridor of the hospital.

There are six approaches to the hospital by the various streets in the district; five of these were closed by burning buildings and piled debris, and the sixth was rapidly reaching the same condition, as a burning warehouse would probably fall and cut off all means of escape. The police of the district now ordered the evacuation of the hospital with the exception of the fire squads. Soon the ambulances arrived and patients and nurses were hurriedly evacuated. The next morning the hospital stood alone in the midst of acres of burned buildings, but by 9 o'clock part of the staff had returned and the hospital was once again open for the reception of casualties.



Left: Main staircase of the medical building shored up after an attack in which a bomb penetrated the roof, completely demolishing the stairs and elevators.



Right: A bomb exploding in this subway forced upward the floor of the ward above it. Beds were hurled around and a heavy piano was thrown into the air.

## England's "Envelope System" Settles

# The Question of Identity

S. R. SPELLER, LL.B.

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EVERY man, woman and child in England has a personal identity card, with the owner's name, address and specimen signature on it, together with a personal registration number. This card has to be carried about and produced on demand except by such persons as mental patients whose cards, with other records, are kept by the hospital authority and young children and babies whose parents or other persons in charge keep the cards.

**Hospital Employees:** Further special steps have been taken for checking the identity of key workers, such as hospital personnel, under the National Registration Scheme but because these measures are confidential for reasons of security, it is not possible to refer to them more specifically except to say that they entail some elaboration of the identity card; how this could be done in America will occur to readers.

**Patients:** According to Emergency Medical Service instructions, as issued by the Ministry of Health, to avoid unnecessary repetition of personal particulars an envelope is filled in for each patient admitted to a hospital and, in addition to the general information on the outside, it is used for the collection and safe-keeping of all original records of treatments, including special reports and x-ray films. The original instructions concerned primarily casualties, service cases and other patients admitted as E.M.S. cases. In practice, especially as the government accepts responsibility regarding the evacuation of all patients, the instructions can be considered as of general application.

The basic rule regarding transfers of patients, whether in an emergency or not, is that all records are inserted in the envelope and transferred with the patient. In emergencies the practice in some hospitals was to pin the envelope to the patient's blanket. Also, the nurse traveling with a group of patients would have with her a list of all the patients in the group.

In some hospitals no special procedure is in existence for adults, beyond the transfer of records and a full list of names either with or in advance of the patients, as it is considered that adult patients, unless dangerously ill and unconscious, are able to announce their own identity. Seriously ill patients would be accompanied by a special nurse in any case, but most hospitals would deal with patients who were unable to give their own names in the same way as with children.

**Children:** All children are labeled as a routine matter in most hospitals. A washable label marked with all necessary particulars is attached to the child's ankle or toe and is never removed. Usually, the name, date of birth, address, religion, diagnosis and name and address of next-of-kin are given. When evacuation is carried out the case papers and a list of patients are, of course, transferred also.

A slight variation in the obstetrical department of one hospital as regards new-born infants is the sewing of a name tape round the baby's wrist at the time the first bath is given.

**Mental Cases:** For evacuation purposes labeling as for children would

be the most usual procedure for mental patients, and in the case of a destructive patient, it might be necessary to resort to a marking in ink or pencil on his back. It is usual in any case to attach name labels to all articles of clothing belonging to mental patients.

When patients are evacuated from a mental hospital they are usually accompanied by members of the staff who can identify them. All documents relating to each patient, such as case book sheet, reception order, transfer sheet and National Registration identity cards, are sent, as is all personal property. The case book sheet contains a description of the patient (age, height, weight, color of hair and eyes) and sometimes a photograph.

This information is based on official E.M.S. instructions and on information obtained from the following hospitals and hospital authorities:

1. The London County Council, which controls 100 or so hospitals of all types, comprising 24,201 beds. (Before the war the total bed complement was 36,229.)
2. The London Hospital, Whitechapel, London E. 1, which is the largest voluntary hospital in England.
3. North Middlesex County Hospital, Silver Street, Edmonton, London N. 18, a 1300 bed hospital, administered by the Middlesex County Council.
4. East Sussex County Mental Hospital, Hellingly, Hailsham, Sussex, a county authority mental hospital with, in war time, more than 1300 beds.



# *There Is No Priority on* **FRIENDLINESS**

**CARL I. FLATH**

ADMINISTRATOR  
CHARLOTTE MEMORIAL HOSPITAL  
CHARLOTTE, N. C.

**A**LL hospitals in the country, and particularly those in the highly industrialized areas, are experiencing great difficulty maintaining normal service. All have experienced shortage of personnel, both professional and lay, and are discovering that equipment or supplies which, under normal conditions, were considered essential are no longer available. True, little can be done to prevent these unfortunate developments, but it seems to me we can substitute something that—to some degree at least—will offset their effects.

That something is an intangible quality of which, in war or peace, there should never be a shortage in hospitals. It incorporates sympathy and understanding, kindness and pleasantness, thoughtfulness and love in our attitude not only to the sick themselves but to troubled relatives and friends of the sick. I am afraid too many of our hospitals in normal times have been inclined to forget the importance of such an attitude and, in becoming so absorbed in the scientific, professional aspects of their work, have lost sight of the fact that the patient is a human being who needs these intangible attentions just as much as he needs scientific care.

## **Hospital Preferences Surveyed**

Some time ago I had occasion to visit a community of about 100,000 people. There are three hospitals serving the area and I was interested in knowing how the public felt toward these hospitals, two of which are as well equipped and as scientifically administered institutions as can be found in the country. I talked to more than 100 people on the street, asking them which one of the

three hospitals they would select if it became necessary for them to be hospitalized, and their reasons for choosing a particular hospital.

In some cases a hospital was preferred because it was newer or bigger or appeared to be cleaner than another, but, in the main, it was preferred because the person being questioned, or a friend, had been a patient in one hospital or the other and he or she was pleased or displeased with the service, the atmosphere of kindness, sympathy and understanding in the care of the patient and the hospital's relationships with relatives and friends.

The point is, that while modern equipment, efficient scientific apparatus and highly organized departmental functioning are important to you and me as hospital people—for we are in a position to measure their value—nevertheless, the rank and file of our patients are not greatly concerned about these things. So while it is our duty and responsibility to provide the best in physical equipment and the best quality of scientific professional care, we should not do so at the expense of forgetting the patient as an individual.

In this connection I feel that hospitals can offset many of their current problems, such as decreasing personnel, equipment and supplies, by endeavoring through all available personnel to render more sympathetic and understanding care. This involves repeated emphasis upon the need for such an attitude to every level of hospital personnel having any contact whatsoever with patients and relatives, and it is my feeling that if hospitals are able to develop and maintain this spirit among admitting clerks, office personnel, nurses, maids and dietary personnel, they will not only retain a favorable

attitude toward themselves in these days but will be creating new friendships for the future.

In the face of rising costs of commodities, equipment and personal services and the necessity of passing these costs on in increasing amounts to the sick public, we might well wonder how it is possible to make new friends.

Increases in rates of from 10 to 25 per cent have already become effective in many places, but we all know that such increases have been dictated by necessity, not simply to keep step with general inflationary tendencies. In this connection, if we are to avoid misunderstanding and criticism from the public, we must overlook no opportunity to justify such increases. We must not let the feeling develop that hospitals are taking advantage of the current crisis to "gouge" the public by charging all that the traffic will bear.

You and I know why it has been necessary to increase rates all around, but have we not a responsibility to acquaint the paying public with the causes?

## **Public Has a Right to Know**

How can hospitals tell their story to the public?

1. Carefully thought out and worded press releases can be prepared that will give the public the facts. The public should be told what has taken place in respect to hospital costs. The public should be told how long hospitals have gone on trying to absorb such increases at rates established under normal conditions. Today this is news—the press will welcome it and it will make friends for you.

2. The same sort of story might well be presented in booklet form for distribution to patients, the medical staff, nurses and other personnel. In other words, we shall have gone a long way in overcoming dissatisfaction with, or suspicion of, our increasing rates if all personnel associated with the hospital, to whom comments in this connection might be directed, is placed in a position to give an explanation that is intelligent and "holds water."

In the over-all planning of protective services the hospital's effectiveness will be largely dependent on the smooth functioning of related community agencies. It is, therefore, of the utmost importance that hospitals

Presented at the Tri-State Hospital Assembly, May 1942.

be represented and take an active part on emergency planning boards of all kinds.

In this connection, it will generally be the hospital's responsibility to coordinate emergency medical services, including the organizing of surgical and medical teams and working with the Red Cross, transportation services and nursing groups, to function as the "hub" of the entire civilian defense plan for the care for the injured. As a result of these necessary relationships, there seems to me to be an opportunity for hospitals to create for themselves new contacts and associations which later may prove to be extremely valuable from the standpoint of inspiring better community understanding.

It is evident, in certain communities at least, that the present emergency has already brought about a closer understanding and, in a manner that never seemed possible before, cooperation among many community agencies, all of which are interested in public welfare but in the past have carried on in a rather independent way. Such relationships should reflect favorably on hospitals for the present and make friends for the future.

Perhaps the most effective approach to creating new and lasting friendships in the present emergency is through the hospitals' relationships with the thousands of temporary voluntary workers who are coming into the field to replace professional and semiprofessional workers who have left or to complement the work of those remaining.

The voluntary lay personnel now being brought into the hospital service activity to fill a temporary gap should be considered more than simply patriotic individuals and willing workers with whom we are for the moment burdened. Such volunteer workers, we must recognize, are essential to our continued effective operation for some time to come. Therefore, there is imposed upon us a responsibility to see not only that they are properly trained for present duties but that the hospital and its activities are so interpreted to them that in the days to come they will go back to their circle of acquaintances with a broad concept of the hospital as the lifesaving station of the community and an indispensable agency of community welfare.

# Don't Make a Racket of National Hospital Day

CAPT. NORMAN B. ROBERTS

U. S. ARMY MEDICAL CORPS

IN A great industrial country like the United States, the material advantage of any occasion is likely to climb into the driver's seat, unless ruthlessly dislodged. We have all seen Mother's Day become one of the greatest commercial rackets our nation has ever seen. Father's Day was practically started with a view to its commercial advantage. Christmas, Easter, Thanksgiving and many other holidays have been exploited.

Shall this happen to National Hospital Day? I think I can hear the answer in no uncertain tone—No! But there is a danger. For the past several years some hospitals have set National Hospital Day as a day for receiving gifts from the people of the community. True this has not developed to an alarming extent to date, but it is being done in good hospitals. This year I have read many articles of news from the press reporting successful "linen showers," "bake sales," "dances" and many other fund-raising "stunts" put on by hospitals in connection with their National Hospital Day observance.

National Hospital Day is not a day for extracting funds from the people of our communities under any guise whatever. It is probably true that these projects have seemed harmless when started by some auxiliary or department of the hospital. On any occasion other than National Hospital Day they would have great publicity value, even if little material gain was realized.

I have tried to analyze this trend that seems to be creeping gradually into some institutions and believe I have arrived at a partial answer. For many hospitals—in fact, too many—National Hospital Day observance is their whole "public relations program." This was never the intention of its founders, nor has it been the intention of any of the national committees. In so doing, National Hospital Day observance becomes an arduous duty instead of the

culmination of a pleasant and successful public relations program. No hospital can work into one day's observance all the multitudinous activities that should have been spread out during the entire year.

Alden Mills in his book, "Hospital Public Relations," makes this statement: "National Hospital Day should be one feature of such a program but not, by any means, considered as an entire program. The objectives of National Hospital Day in a particular institution should be made to coincide with the objectives of the public relations program as a whole; the methods used to set up avenues of communication between the public and the hospital should harmonize with and supplement the methods of the larger program."

"The larger program" may well contain these various fund-raising projects. Such projects are valuable public relations stimulators in addition to their material advantage to the hospital but should be held at a time during the year other than May 12. Let us keep National Hospital Day and its observance in our respective communities free from commercialism and material gain to ourselves or anyone else.

Let us invite our friends and those whom we want to cultivate as friends to our institutions as nonpaying guests on this one occasion. Let us use this opportunity as a time to report on our stewardship in the management of "their" hospitals by demonstrating, as far as possible, the services available for the care of the sick and injured.

National Hospital Day has reached maturity. It is just about the only nationally observed day that has not been commercialized. I doubt if it ever will be commercialized, insofar as its national observance is concerned. Whether or not it loses its value as a community project depends on the individual hospitals in their own communities.

# Addressed to VOLUNTEERS

*Your success or failure depends upon your conscientiousness, behavior and attitude*

**MRS. FRANK E. ADAIR**

GENERAL CHAIRMAN, WOMEN'S COMMITTEE  
UNITED HOSPITAL FUND, NEW YORK

WHEN a volunteer enters a hospital she must conform to the age-old hospital traditions that have existed ever since the founding of the first training school for nurses. The so-called "professional attitude" is based on tradition. In volunteering, you assume a moral and spiritual obligation toward your work and your hospital.

Your success as a volunteer can be evaluated in three ways:

1. The conscientiousness with which you perform your duties.
2. Your behavior and your understanding of ethics.
3. Your attitude toward your work.

## Must Uphold "Unwritten Law"

Let us take up point 1, "the conscientiousness with which you perform your duties." You may interpret "duties" as actual work. It is only part of your duty. You will find in the dictionary that the word "duty" means "that which one is bound by any natural, legal or moral obligation to do." Therefore, as a volunteer, it is your moral obligation—your duty—to uphold the unwritten law of all volunteer workers.

You must appear for work on the days on which you are expected. It is your duty to get to work on time and to remain at work through the entire period agreed upon. One un-

reliable volunteer can do infinite harm; one volunteer who fails to show up for work when she is expected can throw the whole volunteer system out of order and hurt the reputation of the entire department.

It has taken years of conscientious work on the part of volunteers to establish the reputation for dependability that they are now beginning to hold. To keep that reputation is the obligation of each one of us.

For success as a volunteer, you must conform to professional standards not only in the quality of the work performed but also in your behavior. We now come to point 2—"your behavior and your understanding of ethics." Forget your civilian type of life and learn about hospital procedures. Let the doctor precede you into the elevator or through a door. Do not be familiar or discuss personal matters while you are on duty. Always rise when a doctor enters the room. These things may sound unimportant but remember that doctors are accustomed to these traditions and they notice any failure in conforming to them.

Your uniform should be kept clean and neat. Excessive make-up or jewelry should not be worn. Hats should always be removed when you are in uniform even though you are in the hospital for a short time only. You should wear sensible shoes. You are not allowed to smoke or chew gum while on duty. Because you wear a uniform, you are often

thought to be a person in authority so be careful never to give out medical information or to answer questions that might be interpreted by the patient as coming from one in authority.

You must not seek medical advice for yourselves. Volunteers sometimes feel that they have a splendid opportunity to get free medical care. Do not visit other parts of the hospital without first asking permission from your chairman. Your work brings you in contact with sick people. For your own protection you should be careful to wash your hands thoroughly before leaving the hospital. You should not give presents to the patients. Gifts indiscriminately made may seriously upset the medical and social treatment of the patient or his family. If you are in doubt as to any procedure, do not act upon your own initiative but consult your superior.

It is entirely natural to be interested in the patient, but do not let this interest grow into curiosity. Don't ask questions or discuss a patient's illness with doctors or nurses or your fellow workers. You will probably hear many confidences from the patients themselves. You will also hear doctors and nurses discussing a patient's illness or her family situation. All such knowledge should be regarded as strictly confidential.

## Doing Routine Work Is Not Enough

Point number 3: "Your attitude toward your work." One patient badly treated can hurt the reputation of the hospital. Merely doing your routine work is not enough; you must bring to your work a cheerful and sympathetic attitude at all times.

Sticking to the routine of your job with the wrong attitude is worse than not doing the job at all. You have the opportunity of doing the little things that are so important to the comfort and happiness of the patient. The doctors and nurses would, of course, like to do these things, but they simply haven't the time.

Your responsibility is just as great as that of any member of the professional staff. If you remember this fact and all that it implies and if you perform your duties with a high sense of honor, you will have the satisfaction of knowing that you are making an indispensable contribution to an all-out war effort.

Abstract from a talk before the United Hospital Fund and Civilian Defense Volunteer Organization.



# Administrator's Silent Partner

*A guide for new employees and a refresher for the older ones, the precedent book is a valuable silent assistant to the busy administrator. As such, it is well worth the time and effort spent in keeping it up to date*

LILLY D. HOEKSTRA

ASSISTANT SUPERINTENDENT, ST. LOUIS CHILDREN'S HOSPITAL, ST. LOUIS

**E**VEN now when time is valuable because of the many additional duties we must squeeze into our twenty-four hour day, hours spent in writing or revising precedent books are profitably spent because many new employees are unfamiliar with our routines, policies and procedures. These new employees must ask questions and an up-to-date complete precedent book can be a silent administrative assistant, the special duty of which is to answer these questions correctly without necessitating any increase in the salary budget.

Thus, the time of department heads can be used for other important duties. It must be borne in mind, however, that there are questions regarding exceptional cases that will require the attention of the department head because procedures cannot be so standardized as never to recognize exceptions to the rule.

Not only does the up-to-date precedent book serve as a guide to new employees, it also serves as a refresher for the older ones. Some procedures are used so infrequently that we are not familiar with details concerning them and a book to which one can refer affords the most efficient handling of the procedure.

Procedure books include standing orders of two types: (1) professional, dealing with the technic and duties in the care of the patient, and (2) administrative, dealing with all other procedures but particularly with departmental relationships and with handling the public. It is well to have each type in a separate bind-

er. The professional orders combined with some things taken from the administrative group may make up a manual to be presented to interns and even to nurses.

Particularly in a large hospital with a large intern staff an intern's manual, which may be a partial combination of the two types of standing orders taken from the hospital's precedent book, can be helpful in orienting and educating this group with increased efficiency and little trouble. Each intern can be presented with a copy of the manual when he arrives at the hospital.

The intern's manual is not to be confused with the precedent book as the manual is in printed form and is usually used for an entire year without any revision. Furthermore, it contains only those orders from the precedent book pertaining to the group for which the manual is made.

When writing or revising standing orders it is well to keep in mind certain things:

1. The standing orders either must originate from the superintendent or assistant superintendent of the hospital or must be written by the department head and checked for accuracy and signed by the superintendent or assistant superintendent. In the event that orders are not written by the superintendent or assistant superintendent, both the author's signature and that of the superintendent or assistant superintendent should appear on the standing orders since only the administrator and his assistant have authority over all de-

partments; yet, the authority of the order should be shared with the department head who originated it.

2. The binder for the standing orders should be a loose-leaf book so that routines can be added or discontinued without disrupting the entire book. Strong construction of the binder permits hard wear. A good grade of flexible leather wears well. An inexpensive binder will prove satisfactory for copies that are not used frequently. The binder should be large enough to permit the addition of pages as new orders are added and to accommodate paper large enough to eliminate the necessity of crowding words. A 6 by 9½ inch paper is satisfactory. The binder should have at least five large rings (1½ inch, preferably) to prevent tearing of pages.

3. The paper should be of good quality with some rag content; if not, pages may tear out easily as a result of frequent handling.

4. The number of copies of the precedent book must be adequate to allow at least one in each department concerned with the standing orders contained in the book. If all members of the department are not located in the same room or in a space small enough to refer to one book without loss of time or interruption of the work of others, extra copies should be made. Also, if it is the policy of the hospital to have on call during the night employees who carry on hospital business by telephone from their rooms, each of these employees should have a copy. Even though the superintendent may feel

that the people who are on call are perfectly familiar with the routines of their departments, this is a changing world with a constant change in personnel and it is easier to make several extra carbon copies at the time the standing order is written or revised than it is to retype it later.

The superintendent and assistant superintendent should each have his own copy for necessary reference. The head of each department concerned with routines should have his own copy so that he can revise standing orders at his convenience without depriving other members of his department of the book.

The stenographer who types the standing orders should have a book and should indicate at the bottom of each standing order the department and individuals to whom a copy of the order was given. This information may also be helpful to the superintendent and assistant superintendent if it is added to their copies.

5. The degree of detail used in writing standing orders must be adequate for clarity. Clear concise statements are important. A book that is too detailed for an older employe is better than one that is not detailed enough for a new employe.

#### **Show Date on New Orders**

6. All standing orders must be dated. If they are original orders on the first typing, the current date may be used. If they are being revised, the date the order was first typed may be placed first with the revised date underneath. When orders are recopied without revision the original date is placed first and "recopied date" below. These dates must be indicated by the respective words. In so doing, necessary reference can be quickly made to a copy of obsolete routines kept in the superintendent's office.

To simplify locating information regarding a subject two suggestions are helpful: (1) paragraph headings of the subjects discussed in the paragraph may be used with (2) an alphabetical guide and a complete index. For example, in writing a standing order on the procedure of admitting patients one must bear in mind that this will be lengthy if it is to be clear enough for a new employe to follow. To provide the greatest benefit to the new employe

the procedure should be described step by step. Yet as the employe becomes familiar with this procedure he may wish to refresh his memory on one subject only.

Let us say he has forgotten what to tell the patient or parents about the patient's clothes and valuables. He refers to the index under "C" where he finds "Clothes and Valuables" listed under "Admission of Patients." Using the alphabet guide he turns to "Admission of Patients" under "A" and looks through the pages at the paragraph headings, which cannot be alphabetized because this procedure is described step by step, but he soon finds a paragraph headed as follows:

#### **Rate Folder**

#### **Visiting Hours**

#### **Clothes and Valuables**

These three subjects, which constitute one paragraph in the standing order, represent in the admitting procedure one step in which the admitting clerk gives the patient a hospital folder and explains visiting hours and regulations regarding clothes and valuables.

Although it might be possible in an index to give the exact page of each subject, each revision of standing orders would then require revision of the index.

Obsolete orders should be brought up to date in detail each time a change is made in the procedure or policy. Some procedures change as a result of political elections in which such city officials as the health commissioner who authorized previous regulations to be followed by hospitals may no longer be in office. It then becomes necessary to write the new commissioner, sending him a copy of previous instructions issued by the health department and asking for his approval or requesting changes. All such letters of authorization should be filed for future reference. One copy of obsolete routines kept in the superintendent's office only may prove helpful for future reference.

It is a serious mistake to revise procedures orally without any written record being made of the change. This may result in misinterpretation and errors, the correction of which frequently requires the time and tact of the administrative department, particularly in instances in which a misrepresentation is made to the

public. An up-to-date precedent book should prevent this.

Recopying standing orders because of soiled or torn paper without giving thought toward simplifying and improving the procedure concerned is a waste of time. Each standing order should be gone over in every detail to make certain that no revision is wise before the order is recopied.

All orders concerned with legal matters should be discussed with the law firm associated with the hospital to learn whether or not new laws affecting this order have been passed, and a letter from the law firm should be kept on file authorizing or advising the procedure to be followed.

Charges should be refigured and revised to cover current costs.

All standing orders must be carefully checked by the individual who signs them before they are added to the precedent book.

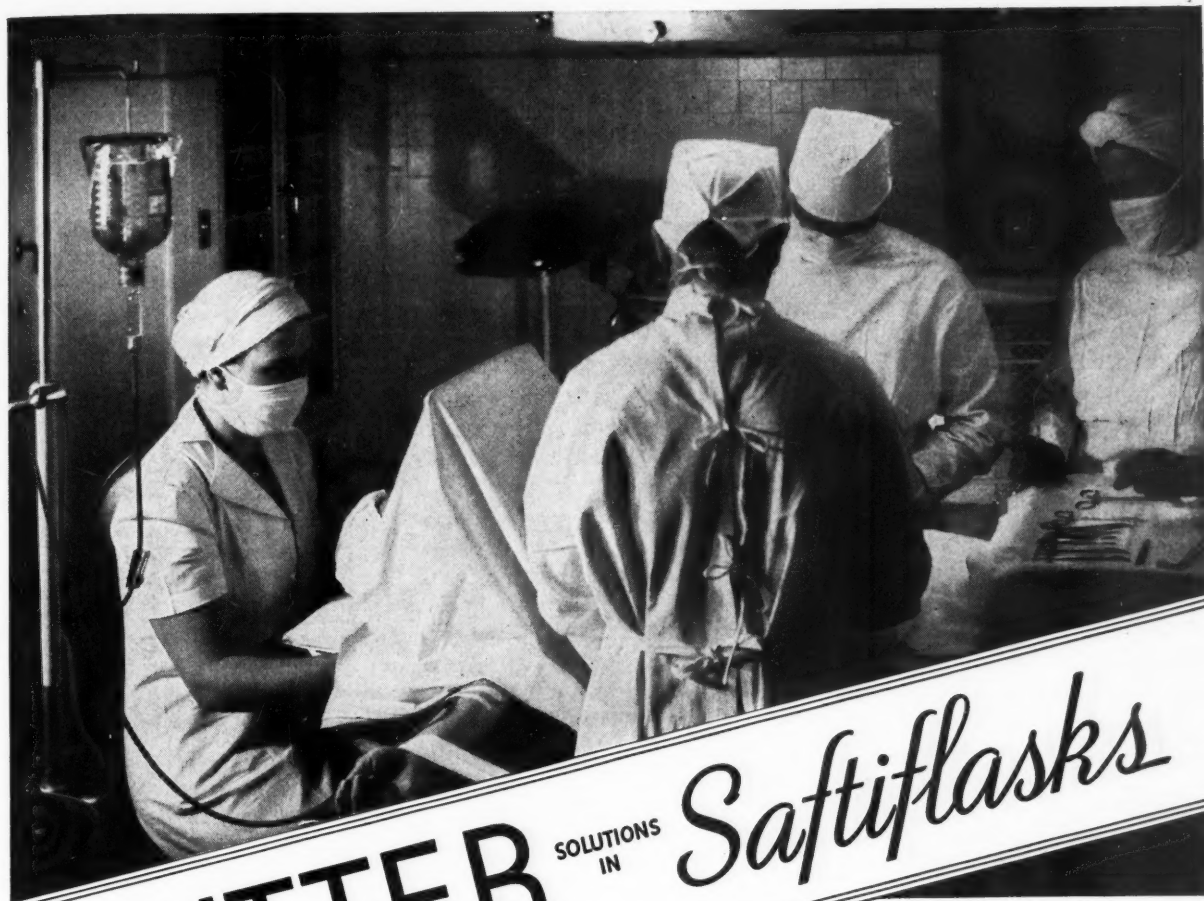
#### **Changes Made on All Copies**

Old copies of standing orders must be removed from all books at the time new standing orders are added. It is well to have the stenographer who typed the orders, after they are properly checked and signed, add them to the books and at the same time remove the old ones from the books.

Each time a new standing order is added to the precedent book or an old order revised, each member of the department concerned should be instructed by the department head to read the standing order and to place his initials at the bottom of the order which indicates that he has read it. This serves as a check for both department head and employe.

One cannot revise a precedent book and then expect to forget it for the next five years, nor will giving only periodic thought to it be adequate. Remember this "silent administrative assistant" cannot tell the new employe that there have been recent changes in the order that are important but have not been added to the precedent book. Only when this book is kept up to date can we expect it to be most beneficial. The entire book should be gone over carefully at least annually to supplement the necessary changes made within the year.

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# SMALL HOSPITAL FORUM

## Coal Is Favorite Fuel

### *In 22 Small Hospitals*

**C**OAL is still by far the most widely used fuel for small hospitals, according to reports submitted by 22 institutions for this month's Small Hospital Forum. Sixteen of the 22 use coal, four use oil and two use gas. Nine of the 16 have stokers, however, so that only seven institutions fire by hand.

Low pressure steam is the prevalent heating system in these small hospitals, 17 of the 22 having such a system. Four have hot water heating and one each has hot air and subatmospheric steam. The one hospital with a hot air system also has a low pressure steam system.

The janitor takes care of the heating plant in 10 of the hospitals and a handy man in two others. An engineer is in charge in seven hospitals. In two of these hospitals, the engineer serves as janitor and in one he is the laundryman. The laundryman takes care of the heating plant in one hospital and in another this work is delegated to a combined fireman and repair man.

The most widely used type of con-

trol is the clock thermostat, which is used in 12 hospitals. Of these, eight state that they have found the thermostats satisfactory, one declares the device is 90 per cent satisfactory and one reports that it is poorly located, being in a section of the building that is warmer than the rest.

Plain heat thermostats (without clock mechanism) are reported by five hospitals. Three express satisfaction and the other two make no comments. Automatic draft regulators are reported by six hospitals, four as satisfactory and the other two without comment. Steam flow meters, reducing valves and motor driven valves controlled by the thermostat are reported by one hospital each. One replies that it has no automatic controls and one does not answer.

The problem of caring for the heating plant at night is frequently difficult in small hospitals. Six correspondents report that they have automatic operation, requiring no night care and one other, which uses oil, reports that the engineer is on call. The night orderly or the janitor

takes charge at night in three of the hospitals. Four hospitals have an assistant or a "night" engineer. Two have a fireman on duty at night and two others bank the fire but have the janitor look at it occasionally.

Asked what methods they are using or are planning to use to conserve heat this winter, the hospitals give a variety of replies. Two of those using oil say that they are setting the thermostat lower. The other two do not reply to the question.

One of the hospitals in which gas is burned states that it is closing empty rooms, setting the thermostat lower for the night and weatherstripping windows. The other hospital with gas is doing the same and is turning the heat down in the power plant during the day when the building is warm enough to be comfortable instead of letting the heat stay on and merely turning off radiators.

At present, there is not as much government pressure for fuel conservation on hospitals using coal. Several in this group, however, have taken steps to conserve heat. One hospital has recently converted to coal. Other steps are: weatherstripping, installing storm windows and doors, setting the thermostat lower, watching temperatures more closely, watching combustion and draft, closing unused rooms, installing a stoker and thermostatic controls, testing different coals to see which gives the best results, keeping doors and windows closed as much as possible, cutting down on heat in various parts of the building.

One hospital, however, writes: "We cannot conserve any more heat than we have conserved heretofore. We have always practiced the most rigid economy. Our hospital is full and we have to use sun parlor space for wards. Since the sun parlor heats poorly, we have installed an oil burning heater there to save 'forcing' the boiler to take care of that space, which would overheat the rest of the building."

Hospitals that wish to find additional means of conserving heat and improving the efficiency of the power plant are referred to the two special studies on this subject in the 1942 *Hospital Yearbook*.

#### REPORTING HOSPITALS

##### COAL

Chadron Municipal Hospital, Chadron, Neb. (30 beds)  
Leaksville General Hospital, Leaksville, N. C. (50 beds)  
W. B. Plunkett Memorial Hospital, Adams, Mass. (50 beds)  
Memorial Hospital of Greene County, Catskill, N. Y. (50 beds)  
Alamosa Community Hospital, Alamosa, Colo. (48 beds)  
Americus and Sumter County Hospital, Americus, Ga. (35 beds)  
St. Joseph's Hospital, Buckhannon, W. Va. (50 beds)  
Boone County Hospital, Columbia, Mo. (50 beds)  
Clark County Memorial Hospital, Jeffersonville, Ind. (37 beds, soon to be 85 beds)  
Plummer Memorial Hospital, Sault Ste. Marie, Ont. (54 beds)  
Holy Rosary Hospital, Ontario, Ore. (45 beds)

Franklin County Memorial Hospital, Farmington, Me. (50 beds)  
Clarksville Hospital, Clarksville, Tenn. (40 beds)  
Brookville Hospital, Brookville, Pa. (42 beds)  
Summit County Hospital, Coalville, Utah (15 beds)  
Sheldon Memorial Hospital, Albion, Mich. (40 beds)

##### OIL

Sarasota Hospital, Sarasota, Fla. (55 beds)  
Kalispell General Hospital, Kalispell, Mont. (50 beds)  
Johnson Memorial Hospital, Stafford Springs, Conn. (48 beds)  
Clark General Hospital, Vancouver, Wash. (52 beds)

##### GAS

John Burns Memorial Hospital, Belle Fourche, S. D. (25 beds)  
St. Mary's Hospital, Winfield, Kan. (50 beds)



LIKE THE TURNIP IN THE OLD FABLE THAT  
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INCLUDING THE MOUSE—TO UPROOT IT,  
FEW DISCOVERIES ARE UNEARTHED BY A  
SINGLE PERSON.

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# ADRENAL CORTEX EXTRACT (UPJOHN)

FINE PHARMACEUTICALS SINCE 1886



## TRUSTEE FORUM

# Social Work Must Tell Its Own Story

*Whether that story will be a serial or a short story will depend upon those who interpret social work to the giving public*

**EDUARD C. LINDEMAN**

PROFESSOR OF SOCIAL PHILOSOPHY, COLUMBIA UNIVERSITY

THOSE who are responsible for interpreting social work to the public, especially the giving public, must now make an important decision. They must determine upon a policy that will serve as a basis for the coming fund-raising campaigns. The current tendency appears to be to present the social work story almost wholly in terms of the war.

If this course is followed the public's understanding of social work will suffer. The plain truth of the matter is this: The people of the United States hardly begin to understand the fundamental meaning of social work. Their past support of social agencies is the fruit of their instinctive sympathy for those who suffer and has little to do with comprehension of a technical approach to human suffering.

### Basic Propositions of Social Work

The story that social work has to tell in this time of war, if it is to be a continued story and not a short short story, should revolve about the following propositions:

1. War does not create any new social problems; it merely accentuates old ones.

2. Social problems are inherent in the social situation and will continue to increase in quantity, in subtlety and in difficulty of treatment.

3. The best formula for thinking clearly about the war and what must be done to win it is to think also about peace and the postwar world.

4. If, as a result of the war, private agencies are decimated, our nation will to that extent have abandoned a precious element of democracy and will have taken a long stride towards totalitarianism.

5. Social work as it has developed in this country, and on its better side, is integral to the democratic course of American life.

The first proposition represents an attempt to avoid subjection to crisis psychology. There is a health problem in this country, a serious one; but if we now insist that health agencies must function at a higher rate of efficiency because we need health and strength to win the war, what arguments are left for a peacetime program? Are we not on sounder ground when we insist that the war has merely thrown into bold relief a health situation that we have thus far neglected—and to our peril? Every war measure undertaken to improve health should also include a sense of direction with respect to health programs after the war is over.

A vast reservoir of liberal support for social work lies untapped because we have not yet succeeded in making clear to the intelligent citizen why social problems are likely to

increase rather than decrease. There are still many persons of high intelligence who seem to believe that there ought to be a final solution for the social problem.

What needs to be said clearly and persuasively is that every advance in the complexity of modern living increases the probable incidence of social unadjustment. Poverty can be eliminated. Does the abolition of poverty automatically do away with insecurity? Families grow smaller wherever industry expands; does this mean that family life automatically improves? A serious student of human nature and of the social process must answer both of these questions in the negative.

The social problem arises from two sets of inescapable circumstances: (a) human beings all have the same requirements but they differ in capacity; (b) every increase in the application of technology to man's adaptation to his environment disturbs the natural normal controls. Consequently, there will be in the future a greater need for social work than at present.

Many individuals complain that this war has somehow brought to them a new type of confusion, namely, a derangement of time. They find that the simplest way of avoiding this difficulty is to restrict one's perspective to immediacy, to think only in terms of the short-range. The psychologists call it the "headline mentality." When this type of mentality becomes serious about this war its usual response is to say: "Let's win the war first and then begin to think about peace and the postwar world." He thereby commits a grievous error.

### Postwar Must Be Considered

Before the war is finished we must have committed ourselves to the kind of peace that has the strongest possibility of abolishing war altogether. And, before the peace has begun we must dedicate ourselves to the rebuilding of our world. Only by keeping these three always together—war, peace, postwar world—is it possible to conduct our lives through this tragic experience without loss of faith and hope.

A curious mood seems now to pervade private social work circles. A decade ago leaders of the private agencies were contemptuous of the public agencies. Now they are

Abstracted from "Channels."





*"I don't know how  
I Ever got along  
without it" . . . .*

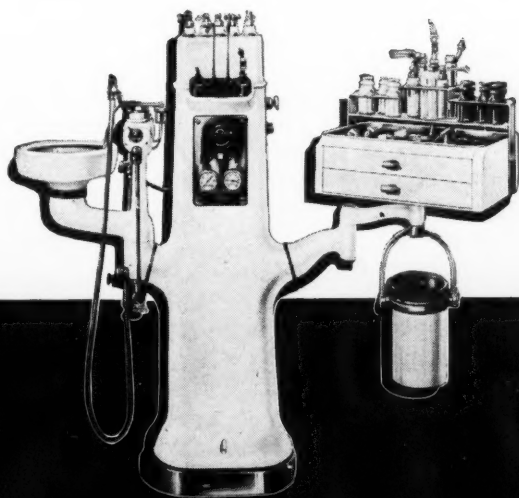
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★ ★ ★

frightened. Both are negative and unworthy attitudes. What the private agencies must do is to present their case, but on its own merits. Private social work does not get better by condemning public social work and, certainly, it will not improve if its leaders go about spreading despair.

What is the case for the private agency? The answer is simple enough but the task of formulating this answer so that it will be clearly and unmistakably understood by the people is another matter. The answer is: a society that has completely abandoned all private enterprise, whether in business, in education or in social services, cannot any longer claim to be a democratic society. A democratic society must remain pluralistic.

This does not mean that it must remain pluralistic throughout, but what it does mean is that when a nation closes the door absolutely upon the private test, when all human activities are subsumed within the authority of the state, the form of the state that emerges is totalitarian, not democratic. It may become totalitarian state socialism or totalitarian state capitalism, but it cannot be democratic.

#### Face Fears Realistically

Those who now state in despair that when this war is over there will be no place for private agencies should reduce their fears to more realistic terms. For example, what they mean is that after this war there will be no more universities and colleges called Harvard, Dartmouth, Wellesley, Columbia, Chicago and Stanford. These institutions will have become governmental enterprises and will be managed from Washington or by politicians of local commonwealths.

Is this what we want in this country? If not, what do we want? If we know, we should say it plainly to the people. If we believe private agencies should exist, then we must also state the purposes they should serve. We cannot continue to say that private agencies must be conserved in the interest of democracy and then operate these private institutions undemocratically. If the people finally consent to the abolition of all private agencies it will be because they have ceased to believe that these institutions serve their needs,

because they have come to believe that private agencies are not in reality on democracy's side. If they are on the side of democracy, how can this story be told to the people?

Like all professions, social work has a better and a worse aspect. Perhaps it will be easier to conceive of the "better" by pointing out some of the features of the "worse." Social work is at its worst when it allows the perpetuation of the Lady Bountiful formula. Social work is at its worst when it is manipulated by a dictator or a clique and thus presents to the community an awkward example of an antidemocratic "island" subsisting within a democratic environment.

Social work is at its worst when its professional representatives become absorbed in "cases" and lose all vital connections with the milieu of which their cases are a part. Social work is at its worst when its agents treat the client as though he were a being of lesser breed and thereby dishonor and demean him even as they pretend to aid him.

These are all familiar complaints against social work and they all have some justification in fact and experience. But there is a better side, a phase of social work that stands clear and clean as an important ingredient of our democratic growth. It is this side that we have not yet learned how to describe to the people. To be democratic implies that you are involved in your neighbor's welfare. Hence, out of American social work has come that great humanitarian spirit that will not permit us to withdraw from human suffering.

#### What Democracy Implies

To be democratic implies that purposive behavior is continuously directed toward the fulfillment of human needs. Here, again, social work's record is admirable.

To be democratic means that there is a constant striving to bring the expert and the layman into working relationships at the point of problem-solving. Social work's performance in this area is spotted but it contains more of the better than of the worse. At this moment a great opportunity presents itself to do useful work not merely on behalf of winning the war but of educating a large number of laymen to a new understanding of the nature of social work.

From the very beginning of this total war we came to understand that there would be need for both civilian and military defense. There has never been a period in American history when there were so many volunteers at work in hospitals and social agencies as in this season of war.

But, alas, this story is not being told. Even those who are participants do not understand it; they do their work in a maze of confusion and with a minimum of satisfaction. It is my opinion that when the war ends these volunteers will throw their uniforms into the wastebasket and run with unseemly haste as far as possible from hospitals and social agencies.

This need not happen. But it will happen if the story isn't told soon and with vigor. Social work might gain literally millions of friends and allies, future interpreters and collaborators if its leaders knew how to relate themselves properly to this new host of volunteers. If they miss this opportunity, it will be because they lack both humility and statesmanship.

#### Interpretation Is Needed

Much of what has been suggested is the responsibility of social work as a whole, rather than of the specialist in interpretation. But the social work interpreter is part of the whole. In addition, he is charged with the specific task of analyzing the social setting and sustaining a progressive relation between the agency and the community. He must, therefore, urge that social work adapt itself to its constantly changing environment and he must emphasize these adaptations to the public.

In many ways social work is being put to its most rigorous test. Its ranks are neither steady nor unified. It is a tragic circumstance that this should be so at the very moment when it becomes certain that the ravages of war will soon call upon this profession to render the greatest services of its entire career.

Fear is no remedy. Pessimism is a sickness. Doubt and hesitancy will dissipate the remaining courage. The situation calls for audacity, but audacity that springs from faith and integrity. If social work is on the side of democracy, it will have a thrilling story to tell in these coming fateful years.

# Milestones in Medical History



## Intravenous Therapy

## Accessories by

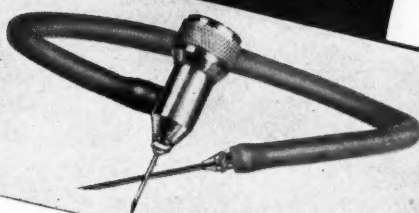
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1935

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1939

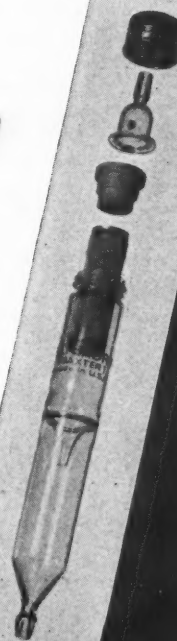
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# *Memo to: Maintenance Engineers*

## *Subject: CONSERVATION*

### *From: WILLIAM OVERTON*

SUPERVISING ENGINEER

MONTEFIORE HOSPITAL, NEW YORK CITY

THE problems of hospitals under present day conditions demand that the engineer employ all his mental powers in planning to conserve equipment, improving existing procedures and devising ways of overcoming the handicaps caused by lack of men and materials.

#### Salvage

An example of ingenuity in devising ways and means of meeting shortage problems arose at Montefiore Hospital, New York, when a manufacturer refused to supply carbon motor brushes because they contained copper pigtail, which required a high priority rating. We ordered these brushes minus the copper, salvaged and reused the material from the old brushes, thereby solving this problem.

No piece of equipment or parts should be discarded until they have been scrutinized carefully and the probability of present or future use has been established. The junk yard and the building and house wreckers might solve the replacement problem in many instances. However, the prevailing market prices must be borne in mind when making such purchases to make certain there is no overcharge. It is not wise to overload the storeroom with an excess of supplies unless intended for immediate or prospective use. Precaution must be taken and prevailing market prices noted when making purchases from dealers in repossessed materials.

Five gallon iron pails that originally contained paint can be cleaned by using the burning-out method or by submersion in a removing tank.

They may then be painted with aluminum paint and serve several useful purposes, such as mopping pails or for sand storage.

#### Purchasing

Sometimes an old piece of equipment is reconditioned to appear as new and bears the price of the new article. Good judgment must be exercised when making purchases of equipment on a competitive bidding basis for a certain specified article, as the lowest price would not be the most important consideration in these times if the availability of repair and replacement parts is overlooked. It might be better procedure to purchase the more expensive item than to face the probability of the cheaper one's being put out of service entirely for lack of parts.

#### Inventories

Inventories should be watched closely to make certain that parts purchased for vitally necessary replacements are used only for the purposes intended. While on the subject of inventories, the idea might prove of interest to other engineers to inaugurate a system for the exchange of parts and equipment by taking inventory of all items not needed at the present time, or where there is some doubt as to their future use, and incorporating them into one listing, each contributing engineer to receive a copy. Details could probably be worked out on a cooperative basis. There may be some articles in the possession of one institution that it does not need and that may be urgently needed by another.

#### Economies

Close cooperation between the maintenance and housekeeping departments should be maintained in order to discourage the use of strong alkalis and abrasives in cleaning metal work, plumbing and lavatory fixtures in order to keep refinishing and replacement at a minimum.

Extinguishing electric lights that are not needed helps to conserve power and to obtain the maximum number of hours from the bulbs. Likewise, shutting off hot and cold water faucets and valves completely not only conserves the fuel necessary to heat the water but will save wear and tear on metal and rubber, seat and washer. In a large institution, the replacement of electric light bulbs, water faucet seats and valves, each containing essential metals, can be noticeably reduced by close attention to these seemingly minor details.

Blackout regulations require the painting of a number of transoms and windows. This will materially reduce the effectiveness of light and, consequently, a large amount of electricity will be consumed, but economy should be practiced by using only necessary lights.

#### Preventing Loss

The rubbish and garbage sent to the incinerator should be watched closely. Articles, such as forks, knives, spoons and surgical instruments, are sometimes discarded accidentally. Only a few minutes is required to look over the garbage to determine if any material can be salvaged.

Laundry employees should be notified to examine pockets of uniforms of employees, doctors and nurses for articles that may have been left in them. Linen should be



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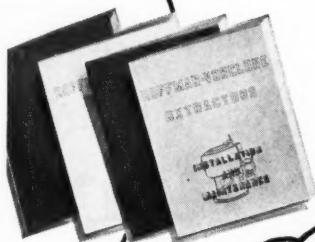
We still have available skilled laundry technicians—to help you establish more efficient linen controls, obtain maximum output from your present equipment and reduce operating costs.



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shaken thoroughly to discover rubber goods, such as hot water bags, surgical instruments and other useful material.

Materials to be stored should be thoroughly checked and kept under lock and key so as to eliminate the theft hazard. Requisitions covering the purchase and issuance of materials should be thoroughly checked.

### Painting

Because more bituminous and anthracite coals will be burned this winter, smoke, soot and ash filled air will necessitate the frequent washing of walls to preserve the life of the paint. Paint film is attacked by the impurities carried in the air, which adhere to walls and deteriorate the film rapidly.

The majority of institutions have to rely on a quick or medium synthetic enamel for painting metal furniture. Most small institutions could not stand the expense of installing a steam drying unit. A high temperature is required for baking synthetic enamels and this equipment is somewhat bulky because of the excessive insulation needed to cover the dryer to withhold temperature.

Infra-red ray baking bolsters the fast curing of urea formaldehyde enamels and has resulted in a new method of hardening this type of enamel which eliminates the former expensive method. Infra-red baking is simple and the equipment does not take up much space; it hardens the painted surface and gives results equal to those obtained when painting is done by a contractor.

### Safety

A program of fire precautions should be enforced more rigidly than ever as much material and equipment cannot be replaced if it is destroyed by fire. Sprinkler heads should be examined for erosion and leaks. Common sense should be exercised by employees and no material should be stored in the vicinity of sprinkler heads as considerable damage can be caused by water as well as by fire.

### Coal

Economies established in the past in power generation and heating by coal are somewhat upset by available quality, price ceilings and transporta-

tion problems. Most of the better grades of coal are consigned to the war production industries on long-term contracts. Some of the deep mines are working at half capacity owing to the labor situation. Therefore, the majority of coals of higher quality cannot be obtained and this condition will prevail for some time.

About the only procedure we can follow is to consider carefully the different types and grades available, with particular attention given to ash and moisture content. Coal dealers, eager for business, will bid on the type of coal required and deliver a blend consisting of two types of coal to maintain a certain analysis and, thus, are in a position to underbid a competitor. It is generally well known that certain dealers have mixed anthracite dust with bituminous coal without immediate detection.

Coal bins and storage piles must be kept at capacity as transportation and weather conditions may hamper shipments during the winter months. In compliance with the advice of our government to all institutions to build up a reserve of coal to relieve transportation and labor, the selection of the type of coal best suited to the equipment and the one that will withstand storage for long periods is the major consideration.

High sulfur content is believed to result in a poor storage coal, but this has not been definitely established. The U. S. Bureau of Mines is not quite definite on this point. However, those who have been consistent users of coal have learned the types and grades with good storage characteristics and the others will be interested in the prevention of spontaneous combustion. Several elements may be responsible for this danger, *i.e.* free oxygen supplied by moisture; improper or careless methods of storage, creating air pockets between layers, or mixing two or more coals, thus causing a chemical reaction.

A coal that has good storage properties should be selected. After the selection of storage space, a ramp of coal high enough to take a truck load from ground level to the top of the pile should be constructed, the truck continually rolling over it to keep the pile well packed down and to force out free air. The top of the pile should be flat with sides tapered. After the pile has been completed

and packed as tightly as possible, care must be taken to see that the top of the pile is shoveled level or on a straight pitch slightly to each side to shed rain water. The sides should be trimmed with a slight pitch and no pocket allowed to collect water.

The Btu. value of bituminous coal after spontaneous combustion is about a third of its original value as fuel. The addition of water used in extinguishing a fire only adds free oxygen. The practice of moving the coal to another location requires additional labor and in some instances may equal in expense the cost of the coal.

The space selected should be high and dry and never in a depression or valley where moisture is likely to settle. If anthracite coal is available, it can be mixed with bituminous coal, provided the proper equipment to consume this mixture is available. The initial cost can be reduced in proportion to the mixture of anthracite and bituminous coals consumed.

### Heating and Ventilating

The lowest possible temperature that does not impair the health of patients should be maintained. Temperatures in dormitories and other parts of the institution can be lowered when they are not in use, or the heat can be turned off entirely after midnight and opened before the employees rise in the morning, so that the temperature of the room is normal at that time. Precaution must be taken against the possibility of pipes freezing.

Ventilating fans should be used only when necessary throughout the winter months or the speed should be diminished below summer levels. Judgment should be exercised so that the occupants of the rooms are not put to any discomfort. The supply of fresh air must be reckoned with and due consideration given to bodily comfort. The tightening and weather stripping of windows and doors prevent infiltration of cold air.

Corridor entrances and doors leading to roofs should be kept closed because they act as flues, cause unnecessary draft on floors below and waste already heated air. Attics and walls should be insulated where necessary. Cooperation of watchmen and employees is valuable here for they can be instructed to close all outside doors and some windows.



## ENGINEER'S QUESTION BOX

### Inspecting Elevator Equipment

Question 7: How often should the various parts of elevator equipment be inspected by the hospital engineering department? By the insurance inspector? By city or state inspector?—E.S.G.

ANSWER: Elevator equipment should be inspected every day and a thorough check should be made once a week when the greasing and oiling are done. Insurance inspectors make their check-ups every three months. City or state inspectors make their inspections about once a year.—LELAND MAMER, *Evanston, Ill.*

### Iron Valves on Brine Lines

Question 40: Is it safe to use valves on the brine lines of our refrigerating system if the body and trim of these valves are of iron?—M.A., Ont.

ANSWER: It is safe to use iron valves and trim on brine lines. We have been using iron pipe and all iron parts on brine lines for many years.—E. W. RIESBECK, *consulting and construction engineer, Chicago.*

### \$5 AWARD TO SILVERMAN

Edward W. Silverman, assistant engineer at Mount Sinai Hospital, Philadelphia, answered the "\$5 question" in the January question box. Mr. Silverman explained the best method of testing thermostatic radiator traps.

### Emergency Light Protection

Question 10: What spots or equipment in the hospital ought to be protected by emergency light and power units? How does the war affect this problem in hospitals in coastal areas?—S.N., Calif.

ANSWER 1: The operating and delivery sections, the emergency department and all corridors, including ambulance entrance. Emergency lighting of elevators is not necessary nor of patients' rooms or other departments that normally do not function at night.—LELAND MAMER, *Evanston, Ill.*

ANSWER 2: Emergency lighting should provide for the ceiling lights, air-conditioning and plug outlets in operating rooms and night lighting throughout the institution. One elevator and a skeleton call system should be available in large institutions.

Over an extended period of time, it would be advisable to have emergency power available for as many sections of the hospital as funds will permit.—J. B. BASIL, *Brooklyn, N. Y.*



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# HOUSEKEEPING PROCEDURES

Conducted by Alta M. LaBelle

## Appearances Do Count

"It is just as important for a maid or porter to present a clean, neat, well-groomed appearance as it is for a nurse or doctor," according to Orpha Daly, housekeeper at Berwyn Hospital, Berwyn, Ill., and few housekeepers will disagree with her. Miss Daly's list of "do's and don't's" for maids and porters includes the following:

Maids and porters must at all times be free from body odor.

Their hair must be neatly combed.

Maids should wear neutral colored hose and low-heeled dark shoes with rubber plates on the heels.

They should not wear bright nail polish or jewelry.

Maids and porters should wear suitable uniforms that have been selected by the institution on the basis of practicability, ease of laundering and good appearance.

Incidentally, it is Miss Daly's feeling that employes should purchase uniforms at cost and that the hospital should launder them without charge. The em-

ploye will take better care of his uniform if he buys it himself; moreover, it saves the hospital a large investment for uniforms.

• •

## Employee Meetings

Most housekeepers are agreed on the value of periodic meetings with their employes at which suggestions for the improvement of the department are offered and problems and difficulties that exist can be straightened out. In the words of Mrs. Julia Siebert, house manager of Winfield Sanatorium, Winfield, Ill.: "Employee meetings are valuable. After two or three minutes of reserve, ideas fly thick and fast and you really see the man or woman who is working for you. Employes should be encouraged to offer suggestions for improving the work of the department. Doing so makes them feel more a vital part of the institution and stimulates their interest. Aside from that, the

employer may gain a great deal from the worker's viewpoint. Meeting the employe on an equal footing and being frank in all matters establish a most cordial relationship."

Mrs. Elizabeth Baird, Decatur and Macon County Hospital, Decatur, Ill., is also convinced that many problems can be solved through the medium of employee meetings.

"Employes should be regarded as friends and made to feel free to express their ideas and suggestions. If they are treated as friends as well as employes they will be willing to take more responsibility and will feel that they are an important part of the institution. The importance of their duties, no matter how small, should be stressed.

"I am always open to any suggestions they may have to offer and often find them helpful in saving time and material."

• •

## Uses for Bulletin Boards

There are numerous ways in which bulletin boards can be used to good advantage, housekeepers have found. At Princeton Hospital, Princeton, N. J., Emma G. Wagner has discovered that they can be used effectively for the following purposes:

1. To notify employes of any change in working schedules.
2. To announce employee meetings.
3. To call an individual for conference in the housekeeping office.
4. As an employes' honor roll. ("Listing on the board the names of those who have done outstanding work may act as an incentive to others to improve their own," Miss Wagner points out.)
5. To serve as a general reminder when work is slipping or needs to be speeded up; also, to let the employes know that their efforts are being appreciated.
6. To give employes a place to list their own ideas and suggestions regarding ways to improve their work. They may have some excellent ideas.

In addition, Miss Wagner suggests that an occasional verse or timely quotation placed on the bulletin board gives a lift to the spirit and creates a feeling of contentment and well-being among the employes.

At Jackson Park Hospital, Chicago, notices of varying degrees of importance are posted on the bulletin board in the employes' restroom. Mrs. Conway, the housekeeper, reports that her employes depend on this board for such information as schedule changes, special duties and blackout orders. "There are at all times notices reminding the employes to conserve on electricity, water, linens and all housekeeping appliances."

## Know Your Linens

Do you know what the average life of a bleached bed sheet is said to be? Do you know how many washings a sheet can stand? Do you know the cause of failure to reach this standard of life expectancy? Do you know how to buy sheets that will meet these standards?

These questions are of vital importance today. Here are some of the answers as set forth by Mildred Burt, executive housekeeper of Mountinside Hospital, Montclair, N. J.:

"A fairly good sheet will stand about 200 washings and its average life is thirteen and a half months. If sheets in use fall much short of this standard, the cause may be any one of several things, but it is probable that a poor quality of material for the work required is to blame.

"How can this be avoided? The answer is to set up specifications and then make sure that what we buy meets our requirements. The federal government specifications or the Office of Price Administration specifications that have re-

cently been set up in connection with ceiling prices may serve as a standard. Government specifications DDD-2-281 for sheets are shown on the accompanying table.

"How can we determine which brands of sheets meet these requirements? Government pamphlets, groups organized to help their members in these very ways, textile laboratories and linen manufacturers themselves are all fertile sources of information on this subject, and it becomes an extremely interesting study once a beginning has been made.

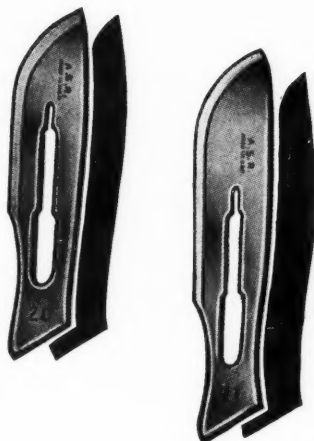
"This study can be extended to other linens in use in the hospital until, finally, we can acquire a definite knowledge of the materials to select when we are in the market for new linens of all types.

"It is assumed that hospitals mark their linens with the date of issue as an aid in determining length of wear. And we must not forget the necessity for frequent checking of the linen delivered to make sure that the brands chosen continue to meet our requirements."

Federal Specifications for Sheets

	Thread Count		Weight (oz. per sq. yard)	Breaking Strength		Sizing (Maximum)
	Warp	Fill		Warp	Fill	
Grade A						
Heavy Muslin.....	74	66	4.6	70	70	2%
Grade B						
Lightweight Muslin....	68	60	4.2	60	50	5%

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## FOOD SERVICE

# We can still be WELL FED

FOR years, the pattern for hospital menus has been soup, meat, potato, vegetable, salad and dessert. All of this twice a day! It isn't necessary. Much more interesting and homelike meals can be prepared if we get away from that monotonous institutional pattern. Soup can be taken off entirely, thus eliminating the preparation, serving and washing of dishes for one entire course. Indeed, unless the meal can be served in courses it is better to eliminate the soup so that the other dishes can be eaten while they are still hot. Nor is it necessary to have the rest of the meal follow that same old routine.

This outline has been followed for so long because it is the one that satisfies the greatest number of people. Patients and employees do not like to see roast ribs of beef replaced with baked stuffed heart or macaroni and cheese. But we can think of our boys who would cheer at having such foods replace some of the ones they have to eat. These are days of changing food habits the world over and we who remain at home will have to adjust ours to the food that is available.

### Different Cuts of Meat Available

The variety of food is getting more limited daily but with all of the restrictions it is possible to be as well fed as we have ever been. In place of fine rib roasts, steaks and chops there will be cuts of meat for stew, brains, liver, sweetbreads and heart. These will meet our needs. On the East Coast there will be limited amounts of beautiful crisp iceberg lettuce, California oranges and other bulky foods that require a lot of shipping space. We shall have to replace these foods with locally grown products. We shall have fewer foods out of season.

Menu-making is a frightful job these days. It is like playing Pussy

From a talk to the Medical Society of the District of Columbia, 1942.

### EVELYN ANDERSON

EXECUTIVE DIETITIAN  
DOCTOR'S HOSPITAL, WASHINGTON, D. C.

*Some of the dietitians' difficulties could be mitigated if doctors would cooperate by ordering special diets only when they are needed and by changing diet orders early instead of just before the meal hour*

Wants a Corner. Today there just aren't enough corners and when we do find one we get chased out right away. With all of the restrictions, menu-making is more of a challenge than it has ever been. However, I am not worried about patients' adjusting themselves to these restrictions. There is not nearly the number of unnecessary and unjustified complaints today that there was a year ago when we had much more variety.

One of our most interesting problems has been to make the change from trained men cooks to inexperienced young girls. Menus had to be worked out around their ability and physical limitations. Methods had to be worked out so that the girls could handle the heavy equipment designed for men. Small cuts of meat had to replace the heavy roasts and food had to be prepared in small quantities.

A big problem today is that of between meal nourishments. There can be little disagreement that nourishments are not necessary except for patients on liquid and certain special diets and that fluids can be forced with water. Meals are close together in hospitals and few people can get the full enjoyment out of them if they have eaten between. Unfortunately, a stay in the hospital has come to mean a feast on orange

juice, coca colas and malted milks—all without cost to the patient.

It takes the time of one girl to prepare and deliver these unnecessary nourishments. And think of the nurse's time that is taken in serving when it is so badly needed for important care. With today's shortage of manpower and supplies, unnecessary nourishments must be eliminated. Money cannot buy these luxuries now because help is not available to prepare them.

By not allowing special diet orders it is possible to make the difference between a busy day for a cook and a difficult day. In these times that may mean the difference between having a cook and not having one. Every time a doctor tells a patient he may have anything he wants someone else has to take time to explain to the patient that he cannot have anything but what is on the menu. Specialists have been employed to supervise the planning and preparation of the meals. They see to it that all requirements are met. To serve special foods is to cater to a whim and there is no place for whims today.

### Diets Should Be Changed Early

Much time and food are wasted in hospitals by having diet orders changed about half an hour before mealtime. Instead of coming in just before lunch and telling the patient he may go on a general diet that noon, why does the doctor not tell him that he is changing his diet beginning with the evening meal?

Orders for hundreds of patients cannot be tabulated in a few minutes and a change in diet order means a change in the amount of food to be sent to various serving stations. If changes are to be carried out too near the serving time it means that more food than is necessary has to be sent to each unit.

Special diets can be satisfactory or otherwise. They are for therapeutic

treatment and should not be ordered to satisfy a patient's likes and dislikes. Every hospital has its routine diets that serve adequately. They should be used far more than they are. Instead of ordering from these diets some doctors will send in a list of foods their patients may have.

In twelve years I have not found a patient who can be made happy with one of these diets. He may stand in awe of the doctor at first and say it is fine but he soon comes down to earth and tells us what he really thinks. Usually, the patients want some simple thing that is not on the

list and which common sense tells them and the dietitian that they can have but which the doctor forgot to put on the list. If the hospital diet outline is used, these wants can be met. The doctor should consult his dietitian and see if the accepted hospital diets will fulfill his needs.

# Ingenuity Is a Good Substitute

WILLIAM A. BRYAN, M.D.

SUPERINTENDENT, NORWICH STATE HOSPITAL, NORWICH, CONN.

THESE are the days that try the souls of administrators who wish to maintain a decent standard of food service for patients and employees. Shortage of kitchen and dining room personnel, rationing and food shortages make food service a veritable nightmare for everyone who has the responsibility of preparing and serving food.

As a substitute for the variety we cannot purchase, additional skills, imagination and ingenuity must be used. The following plan has been put into operation at Norwich State Hospital, Norwich, Conn., to bring out new ideas, menus and dishes.

Every morning a food conference is held in the office of the business manager. The members of this conference are: the business manager, assistant business manager, chef, baker, dietitian, farm manager, storekeeper and superintendent. The subjects discussed include the following:

1. The menu that was served the previous twenty-four hours.
2. Preparation of the menu to be served the following twenty-four hours.
3. Availability of materials and supplies.
4. Farm products ready for delivery.
5. Information regarding inventories for future use.
6. Suggestions for new dishes and comments on waste.

A waste chart is displayed in the office and in the general kitchen on which is recorded each day the per

capita waste for both patients and employees.

In order to experiment with new dishes, we serve a test meal every Tuesday made up of dishes that have never been served before. The superintendent, business manager, chef and baker are always present at this meal and one or two physicians are also included. In addition, a patient and an employee are invited to participate. Criticisms are invited and at the end of the meal a written vote is taken from each one.

If the vote is unanimous the detailed recipe for 100 people and the cost of the materials are incorporated into the hospital cook book, which is being built. This ensures uniformity in preparation.

The story is told of a famous painter who, when asked with what he mixed his paints, replied, "With brains, Madame, with brains." The implication of the story is obvious.

The accompanying recipe for New England clam chowder is a product of this system.

## HOW TO MAKE CLAM CHOWDER—AND WHAT IT COSTS

### New England Clam Chowder (Yield: 30 Quarts—100 Servings)

*Average serving—1 cup*

- 2½ gal. clams
- 11½ qt. water
- 1⅞ lb. diced salt pork
- 30 onions (5 lb.) diced
- 40 potatoes (7 lb.) cubed
- 10 oz. flour
- 20 oz. butter
- 5 qt. milk
- 6½ oz. salt
- 2½ tsp. white pepper

Add measured amount of clams to the specified amount of water and bring to a boil. Drain the stock from the clams, reserving it for use. Grind the clams in a coarse meat grinder. Try out salt pork, add onions and sauté slowly until onions are tender. Combine the clam stock, clams, onions and potatoes and cook

fifteen minutes or until potatoes are soft. Make a cream sauce by blending flour with butter, then adding milk and cooking until thickened. Add the hot cream sauce slowly to the clam mixture. Reheat. Do not cook the chowder once the milk has been added.

### Cost of Chowder to Institution, Priced as Served on Sept. 8, 1942

2½ gal. clams @ \$2.50 gal.	\$6.25
1⅞ lb. salt pork @ \$.14 lb.	.2625
30 onions @ \$.03 lb.	.15
40 potatoes @ \$.02 lb.	.14
10 oz. flour @ \$.031 lb.	.019
1¼ lb. butter @ \$.4275 lb.	.535
5 qt. milk @ \$.09 qt.	.45
6 oz. salt @ \$.0105 lb.	.003
2½ tsp. pepper @ \$.0118 oz.	.00018

Total for 100 servings	\$7.80968
Cost per serving	\$0.078

*As long as it lasts—*

**LUCILLE THOMAS**  
ASSISTANT DIETITIAN  
ROOSEVELT HOSPITAL, NEW YORK

## *Let's Have GOOD Coffee*

**H**OWEVER radically coffee tastes may vary, as they invariably do, on one point there can be no disagreement—better a single cup of good coffee than two or more that are poor. This means that the dietitian must do her best by the coffee she is permitted to serve, whether it is limited to one cup per patient per day or to one cup per patient each meal.

Three steps must be carefully considered in any coffee conservation program: (1) the kind of coffee to buy; (2) how it can best be stored, and (3) its preparation. Irrespective of the blend, and here the only answer is to try and try again until a product is attained that meets the approval of the majority, the coffee must be fresh. Better results are obtained from inexpensive coffee freshly roasted and ground than from a more expensive blend that has gone stale.

### **Purchase Little at One Time**

For this reason, it would be better to purchase only a few days' supply at a time or perhaps to buy the roasted coffee bean and grind just before using. All coffee beans, however, are not necessarily freshly roasted. The only sure way would be to buy green coffee and roast and grind it as needed. Unfortunately, this is not possible except when the special equipment for roasting is available.

Having exerted the greatest care possible in seeing that the coffee is freshly roasted and ground, the next problem is to store it properly. Coffee starts to lose its delicious aroma soon after roasting and deteriorates still more after the bean is ground unless it is carefully stored.

Unquestionably, the safest way to store coffee, and remember we are going to store no more than is absolutely necessary, is to keep it in a cool, dry place where no draft can

reach it, for drafts remove the volatile oils. Nothing dissipates the aroma more quickly than to keep it near a stove or some other warm spot. Always make sure that containers are tightly sealed. Waxed paper or heavy paper bags should be kept closed at all times.

Now something about the grind. Steel-cut ground coffee is the most economical because less is required to make a good strong cup. From such a fine grind it is sometimes possible to get as many as six more cups per pound. Its storage, however, becomes a problem because the volatile oils disappear more quickly when the coffee is ground so fine.

### **Clean Equipment Essential**

At this time it would be well to review coffee-making technics. Rule one is that all equipment be kept immaculately clean. This does not mean giving the urn a haphazard rinse but cleaning and scrubbing it carefully. Second, measure accurately. Why deliberately make more than is required? Despite the fact that we may be able to find use for left-overs, this is no excuse for waste. Never let coffee come to a boil. Finally, serve it just as soon after making as possible. It should be ready about the time patients are starting to eat. Coffee made too long in advance assumes a bitter taste, the result of a disagreeable infusion of coffee ashes.

At Roosevelt Hospital, New York City, we make coffee in the urn for the cafeteria and the employees, with 1 pound of coffee to 2½ gallons of water. The water can be increased to 3 gallons to stretch the beverage further. On the private floors coffee is brewed in glass coffee makers. In each instance we count the number of cups that are needed and make just that amount.

At present we are serving two cups per day to the nurses and the

employees and one cup per meal to the private patients. However, in the wards and semiprivate rooms only one cup a day is allowed. Previously we could get from 45 to 50 pounds of coffee for private patients but this has been cut to 36 with the prospect of being reduced still further, which would mean one cup a day for them.

Despite the care that may be taken in measuring the coffee, there will be a certain amount left over; not much, we hope. This should be kept in a cool place and reheated in a glass container; otherwise it may develop a metallic taste. Aside from using such left-overs for flavoring, that which is not fit for any other use can be used for coffee enemas.

We are hearing more and more about food extenders. Chicory is the most common coffee extender. A certain amount of chicory is more appetizing to many than the straight coffee. It would be undesirable, however, to have the ratio run higher than one part of chicory to four parts of coffee. If the situation becomes more acute, it is likely that we shall see more coffee substitutes on the market and cereals will probably play an important part.

### **If We Have to Cut Still More**

Looking into the future no one can prophesy what steps we may have to take to conserve the coffee supply. We may be urging our patients to try spiced fruit juices as a substitute. Replacing coffee with at least one cup of tea a day would also help and serving a demitasse instead of a large cup would automatically reduce the consumption.

It has been suggested, too, that we use more thin cream. But, again, this would raise opposition from the large group of coffee lovers. It would be better, therefore, as long as we can serve coffee at all, to serve only the best, to which we have given our best.



MAKE THE MOST OF YOUR SHARE... IT'S

# TOO GOOD TO WASTE!

COFFEE, fragrant, delicious, and energizing, is always Too Good to Waste. But especially now, every effort should be made to get full enjoyment out of the supplies available.

## NO RESTRICTIONS HAVE BEEN PLACED ON QUALITY!

- . . . One good cup of pure, delicious coffee is better than two cups of unsatisfying, adulterated brew.
- . . . When you buy coffee, you're entitled to unadulterated coffee . . . be sure you get it.
- . . . Trying to "stretch" coffee by adding adulterants or extra water will prove a disappointing experiment, and only waste your precious supply.

The coffee situation is due to present shipping conditions and not to the amount of coffee that is being produced. The coffee producing countries are cooperating in every way to improve this situation. In the meantime, coffee is, more than ever, TOO GOOD TO WASTE!



# COFFEE

## **THE FRIENDLY DRINK . . . FROM GOOD NEIGHBORS**

**PAN-AMERICAN COFFEE BUREAU**  
In cooperation with  
**THE NATIONAL COFFEE ASSOCIATION**  
BRAZIL    COLOMBIA    COSTA RICA    CUBA  
                 DOMINICAN REPUBLIC  
EL SALVADOR    MEXICO    VENEZUELA  
**BUY UNITED STATES WAR BONDS AND SAVINGS STAMPS**

# Meat Cuts to Help Conserve

## BEEF

Blade and Round Bone Chuck	
Roast or Heel of Round Pot Roast	Pot roast with noodles or vegetables
Plate	Roll for pot roast or cook in water and serve with horseradish
Flank	Bake and stuff or use for Swiss steak
Neck Meat	Stews, ground meat, soup
Short Ribs	Prepare like tiny pot roasts
Ground Beef	Loaves, patties, balls or in casserole dishes, soup, chile con carne
Shanks	Soups with barley, rice or vegetables
Brisket	Corned or fresh; cook in water
Ox Joints (not restricted)	Braise with vegetables

## VEAL

Bone in or Boneless Shoulder	Roast or pot roast
Breast	Bone and roll or pocket and stuff for baking or use for stew
Shoulder Steaks or Chops	Braise or serve with cream gravy
Shank	Soup or jellied veal
Ground Veal	Loaves or patties

## LAMB

Bone in or Boneless Shoulder	Roast or pot roast
Shoulder Chops	Braise or broil
Neck Slices	Braise with vegetables
Shanks	Stew or prepare as curried shanks with rice
Ground Lamb	Patties, loaves
Riblets (ends of ribs)	Stew or split, stuff and bake
Breast	Bone and pocket, or roll with stuffing, or cut and use in stew

## PORK

Spareribs	Bake or cook in water with sauerkraut
Pork Tenderloins	Bake or braise
Neck or Back Bones (not rationed)	Cook in water with rice and vegetables
Hocks	Cook in water with cabbage
Tails (not restricted)	Cook in water with cabbage or lima beans
Salt Pork	Use with baked beans or cut, cover with corn meal and fry
Pork Feet (not restricted)	Cook in water, then bake or serve with vegetables
Bacon	With eggs, waffles, French toast or to season other dishes
Bacon Squares (not restricted)	Cook in water or slice and fry, or bake
Shoulders and Loins	Chops or roasts
(May be available occasionally)	

## SPECIALTIES (Not restricted)

Liver—pork, beef, veal and lamb  
 Kidneys—beef and veal  
 Tongue—beef  
 Hearts—beef, veal and pork  
 Brains  
 Tripe—beef, for soup  
 Sweetbreads—veal, cream, broil or fry

## POULTRY

All kinds are unrestricted.

## SAUSAGE PRODUCTS

All loaves, sausages and frankfurters prepared and ready-to-eat meats when available. Liver sausage is not restricted.

## CANNED MEATS

When made from beef, veal, pork, lamb or mutton, canned meats are restricted.

—American Meat Institute.

## FOOD FOR THOUGHT

American cheese makers are fast learning the art of producing Swiss, Roquefort, Limburger and other foreign types of cheese. In consequence, the loss of import has not seriously hurt this market. American cheddar cheese constitutes the commonest variety now being made in this country. To the cheese trade a "Cheddar" means a round loaf of American cheese weighing from 70 to 80 pounds. A "Daisy" weighs from 20 to 25 pounds. "Young Americas," "Long Horns" and "Flats" are smaller sizes and shapes of American cheddar.

According to agents of the Agricultural Marketing Administration, cheese that is aged must have a fairly sharp and pleasing flavor; otherwise it will be mild and flat. The body must be fairly firm and the texture close.

The cheese may be uncolored or medium colored but must be fairly uniform in color all the way through. The shape of the cheddar must be flat and even, not lopsided or bulging. Its surface conditions should be fairly uniform, dry, properly bandaged, properly paraffined and fairly free from mold, if aged. Good cheddar is about 35 per cent fat and 25 per cent protein.



## The Dietitian's Complaint

*Some little time ago,  
 Each day I'd always know  
 What meals to plan; and never gave  
 a thought  
 To whether we could buy it.  
 I'd merely plan the diet  
 And know that what was needed could  
 be bought.*

*I'd plan two weeks' ahead;  
 But nowadays, instead,  
 I'm lucky when it works out for a  
 meal.  
 The prices are not right,  
 And few supplies in sight,  
 With rationing becoming very real.*

*When I studied theoretics  
 In the school of dietetics,  
 We were told to "take so much of that  
 or this."*

*Heavens knows from where to take it—  
 "We are short" or "we don't make it  
 Anymore; I'm sorry, Miss."*

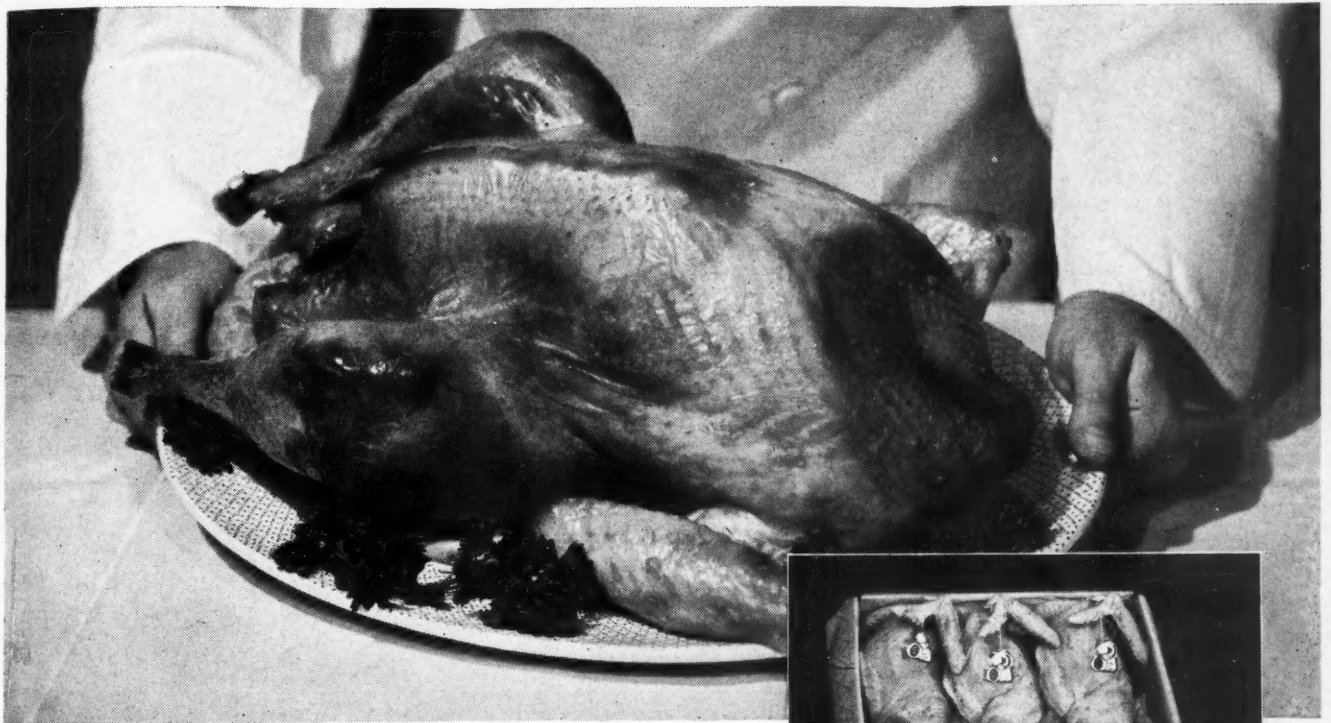
*But I'll find the right solution;  
 I will seek an institution  
 Somewhere in the tropics. That's my  
 dish.*

*Where I will not have to puzzle  
 'Bout the menus they will guzzle,  
 For I'll feed them only coconuts and  
 fish.—J. H.*



Just like making all your servings  
from one bird . . . so

*uniform in quality*  
are these meaty, tender turkeys!



Whether you serve ten or a hundred of these Swift's Premium Turkeys, they'll *all* be plump, tender, and heavy-breasted, with plenty of juicy dark meat—the *pick of the flocks*.

You'll find, too, that *all* Swift's Premium Turkeys give you a maximum number of servings per bird. *Meat, not size, gives them weight.*

These are turkeys specially selected by poultry experts . . . critically examined, graded to

Swift's exacting specifications. The pick of the flocks are tagged Swift's Premium.

Nationally famed and respected as a mark of known, unvarying quality, the Swift name is your *guarantee* of fine turkeys.

This year, be sure that *every* turkey you serve is *identical* in quality—tender, juicy, delicious. Specify *Swift's Premium Turkeys!* Order early from your Swift salesman, or write Swift & Company, Chicago.



Packed in boxes of 6. For easier quantity cooking, all birds in each box are uniform in weight.

The pick of the flocks are tagged →

**SWIFT'S PREMIUM TURKEYS**

*Also* • CHICKENS • DUCKS • GEESE • CAPONS





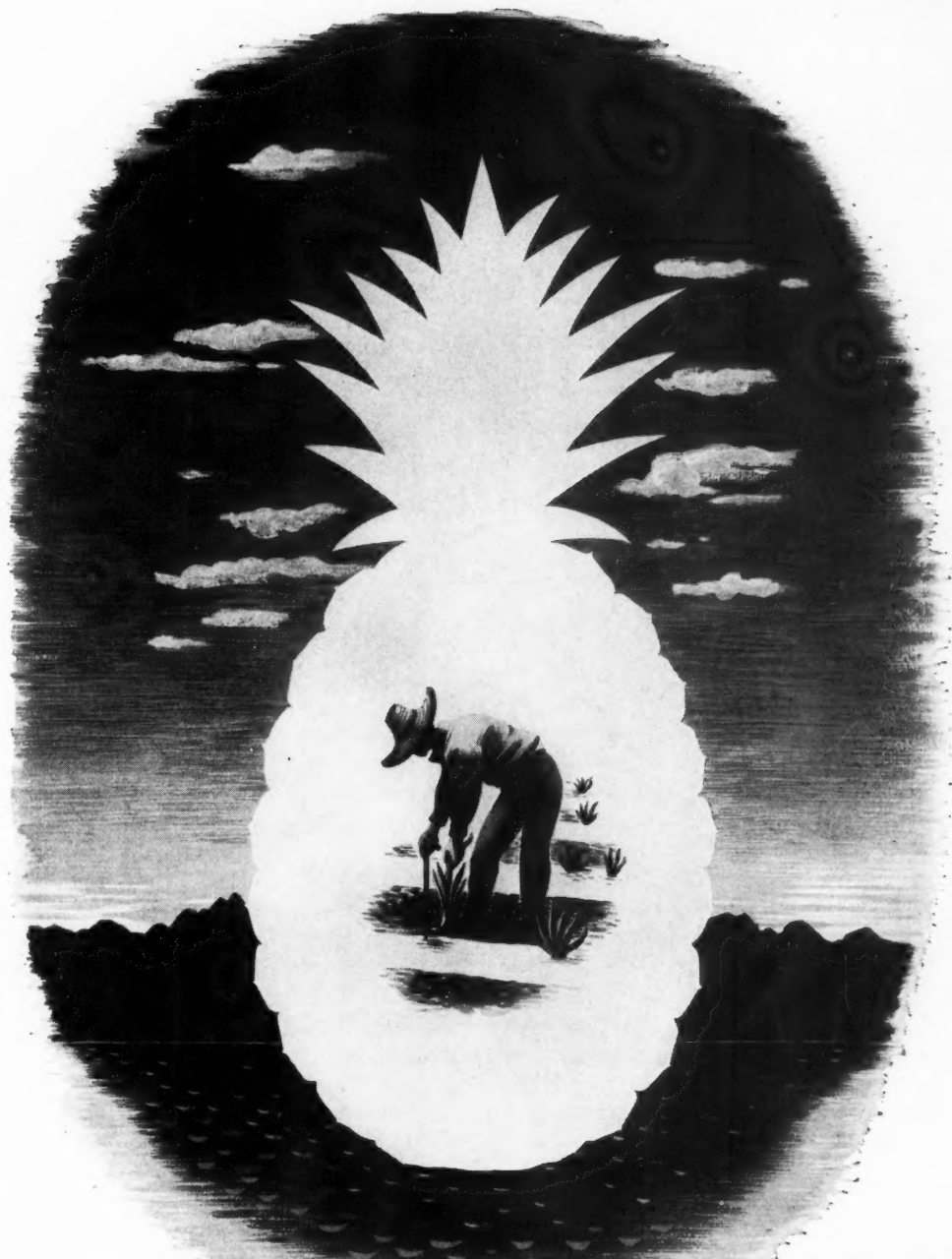
# March Dinner Menus for the Small Hospital

Lucille E. Zilmer

Dietitian, Henrotin Hospital, Chicago

Day	Soup or Appetizer	Meat, Fish or Substitute	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
1.	Pepperpot Soup	Swiss Steak	Mashed Potatoes	Green Beans	Grapefruit and Orange Salad	Caramel Layer Cake
2.	Fruit Nectar	Baked Tomatoes	Creamed Potatoes	Vichy Carrots	Celery, Ripe Olives, Radishes	Tapioca Pudding
3.	Vegetable Soup	Roast Leg of Lamb	Parsley Potatoes	Harvard Beets	Pear and Mint Gelatin Salad	Pecan Ice Cream
4.	Grapefruit Juice	Baked Ham	Whipped Sweet Potatoes With Orange	Broccoli	Rhubarb Gelatin Salad	Filled Cookies
5.	Tomato Bisque	Fresh Salmon	Creamed Potatoes	Frosted Asparagus	Spiced Fruit	Lemon Meringue Bread Pudding
6.	Mulligatawny Soup	Broiled Liver	Escalloped Tomatoes	Whole Kernel Corn	Head Lettuce, Roquefort Dressing	Baked Pears
7.	Consommé With Rice	Chicken Fricassee on Biscuits	Mashed Potatoes	Peas With Mushrooms	Molded Cherry Salad	Butterscotch Ice Cream
8.	Chicken Noodle Soup	Roast Loin of Pork	Browned Potatoes	Brussels Sprouts	Chopped Vegetable Salad	Apple Crisp, Vanilla Sauce
9.	Tomato Juice	Baked Spaghetti and Cheese		Frozen Spinach	Orange and Water Cress Salad	Chocolate Pie
10.	Vegetable Soup	Mutton Loin Chops	Baked Potatoes	Green Beans	Celery and Olives	Apricot Rice Fluff
11.	Barley Broth	Pot Roast of Beef	Mashed Potatoes	Sliced Carrots	Pickled Beet Salad, Egg Slices	Rhubarb and Strawberry Pie
12.	Apple Juice	Broiled Whitefish, Tartare Sauce	Lima Beans	Broiled Tomatoes	Grapefruit and Apple Salad	Cottage Pudding, Chocolate Sauce
13.	Tomato Consommé	Sweetbreads and Mushrooms, en Brochette	Parsley Potatoes	Peas	Cranberry Relish	Honey Baked Apple
14.	Celery Broth	Roast Chicken	Mashed Potatoes	Corn O'Brien	Orange and Avocado Salad	Peppermint Ice Cream
15.	Julienne Vegetable Soup	Leg of Veal	Potatoes au Gratin	Asparagus Tips	Mixed Fruit Salad	Butterscotch Squares
16.	Grapefruit Cocktail	Baked Eggs in Potato Puffs		Buttered Parsnips	Beet Salad	Cherry Tapioca
17.	Consommé With Anelli	Cube Steaks	Baked Potatoes	Creamed Peas and Carrots	Lettuce, Russian Dressing	Peaches, Ginger Cookies
18.	Purée of Vegetable Soup	Baked Pork Chops	Browned Noodles	Cauliflower With Pimiento	Pineapple and Apricot Salad	Raspberry Ice
19.	Bouillon, Lemon Slice	Baked Trout	Succotash	Stewed Tomatoes	Stuffed Celery	Fruit and Nut Gelatin
20.	Cream of Mushroom Soup	Meat Pie With Vegetables	Parsley Potatoes		Apple and Raisin Salad	Vanilla Cream Puffs
21.	Vegetable Cocktail	Southern Fried Chicken	Fluffed Rice	Brussels Sprouts	Cranberry Slice on Endive	Pineapple Ice Cream
22.	Chicken Broth With Noodle Stars	Creole Liver	Escalloped Potatoes	Parsley Carrots	Asparagus and Egg Salad	Minted Fruit Cup
23.	Cream of Pea Soup	Celery Creole With Noodles		Baked Acorn Squash	Pears in Lime Gelatin	Apple Pie
24.	Alphabet Consommé	Veal Birds	Mashed Potatoes	Asparagus Tips	Shredded Carrot and Celery Salad	Vanilla Pudding, Peach Sauce
25.	Scotch Broth	Bacon Strips on Broiled Tomato	Stuffed Baked Potatoes	Mashed Turnips	Pineapple Salad, Cheese-Nut Balls	Orange Tapioca Cream
26.	Tomato Soup, Rice Croutons	Individual Salmon Loaves	Parsley Potatoes	Broccoli, Hollandaise Sauce	Cottage Cheese Relish	Stewed Rhubarb, Oatmeal Cookies
27.	Celery Broth	Broiled Ham	Baked Sweet Potatoes	Green Beans	Tomato and Olive Aspic	Dutch Apple Pie
28.	Fruit Juice Cocktail	Chicken à la King in Toast Cups	Whipped Potatoes	Peas	Assorted Relishes	Baked Fruit Sponge
29.	Vegetable Soup	Roast Lamb, Mint Jelly	Creamed Lima Beans	Glazed Parsnips	Peach and Strawberry Salad	Raisin Rice Pudding
30.	Pear Nectar, Cheese Wafers	Spinach Soufflé	Baked Squash	Cauliflower	Tangerine and Grapefruit Salad	Lemon Sherbet
31.	Purée Mongole	Club Steaks	Rissole Potatoes	Julienne Carrots	Tossed Green Salad	Tutti-Frutti Ice Cream

Recipes will be supplied on request by The MODERN HOSPITAL, Chicago.



- Right now about *three-quarters* of our usual production of Dole Pineapple and about *one-third* of our usual production of Dole Pineapple Juice are going to our Armed Forces.
- Even if you can't get as much Dole Pineapple as you'd like these days, there's good news for the future. We're now planting pineapples for 1945. It takes two years for nature to grow a pineapple. But there are millions who say that the time is well spent. Pineapple's glorious flavor and vitamins will be yours again when the war ends.

**HAWAIIAN PINEAPPLE PRODUCTS**

# DOLE

## Making AMPULES is an ART

*It is also an interesting and worth-while  
challenge to the pharmacist's ability*

**E. C. AUSTIN and A. Z. WALKINS**

PHARMACISTS, CINCINNATI GENERAL HOSPITAL

**I**N THE manufacture of ampules there are the same fundamental points to be observed as there are in the preparation of any parenteral solution. In addition to the careful consideration that must be given the preparation of the solutions, the containers, the ampulling, the sterilization and subsequent culturing for sterility all require great attention.

Of first importance is the selection of the chemicals to be used in making ampule solutions. The same rigid specifications should be insisted on here as would be the case in selecting chemicals for any parenteral solution. They should be of the highest standards, preferably of C. P. or analytical reagent grades. In some instances those of U. S. P. specifications will suffice.

### Solvents Must Be Pure

No less important than the chemicals are the solvents. When water is the solvent only freshly distilled water that meets the N. F. specifications for redistilled water should be considered. When oil or other solvents are required, only those of the highest purity should be used.

The choice of the ampule, that is, the quality of the glass of which it is made, is extremely important. Glass containers having a high free alkali content are not especially conducive to stability of many solutions. For that reason a harder, alkali-free glass is to be preferred. However, when the ampules are used practically as fast as they are produced, some modification of this requirement is permissible. A lot of ampules that

will be used up in a week or two obviously will not be affected by the deteriorating influence of soft glass as much as a lot that is stored for a year or more before being used. Consequently, a so-called "soft glass" ampule may be used for many solutions that will be used a short time after preparation.

Some consideration must be given to the equipment used for filling and sealing the ampules. Methods of sterilizing without promoting deterioration, ways of detecting imperfectly sealed ampules and methods of culturing to determine sterility are other factors that demand attention also.

A good example of the importance of high grade, fresh chemicals for preparing ampule solutions is quinine and urea hydrochloride. A fresh sample will make a perfect solution, while a sample exposed to air for a relatively short time will result in a solution that congeals and solidifies in the ampule after sterilization.

### Careful Distilling Important

Freedom from chemical impurities, gases and pyrogenic materials is important in distilling water and the N. F. tests are fairly reliable in establishing these properties. Most good stills will produce this quality of water.

The type of solution or powder to be ampulled is a determining factor in the choice of ampule glass. Solutions of epinephrine and of dextrose, for instance, are rapidly deteriorated by the presence of free alkali in the glass of the container in which they

may be stored. For such solutions a so-called "hard glass" ampule is desirable, while other solutions, because they are less affected by free alkali, may be ampulled in softer glass. Since it is impractical for hospital pharmacies to stock ampules of a variety of grades, a single grade must be chosen that will be satisfactory for use with any solution.

Aside from the quality of the glass the physical properties of an ampule are important. Ordinarily, ampules with plain stems, or necks, are preferred to those with constricted stems. Length of stems, diameter of openings, thickness of glass and general uniformity are all factors to be considered. To illustrate, ampules with short stems may become so shortened upon sealing as to make them extremely difficult to open, while those with too long stems are subject to high breakage in handling. Breakage is also high in ampules that are too thin. Ampule openings that are unnecessarily large increase the time required to seal them.

### Sintered-Glass Not Satisfactory

The making of the solutions to be ampulled is identical with procedures for making any parenteral solution, regardless of how it is to be packaged. We might mention that at Cincinnati General Hospital we have had some disappointing experiences with sintered-glass filters. Growths of an unidentified nature have resulted in solutions filtered through a sintered-glass filter even though they have been presterilized. Our experience with a good grade of filter paper and with Berkefeld filters has been quite satisfactory.

Certain solutions require special attention in their preparation but, here, in most instances, we go back to the selection of the chemicals and solvents. For instance, Congo Red requires the presence of a monosaccharide, such as dextrose, to aid its solution in water. An ampule solution of sodium nitrite should not be made from a salt that has become yellow as the finished ampule, after being sterilized and stored for a few days, will show a brown flaky precipitate. In preparing a solution of so-



*"... the one reliable  
age-old standard"*

In comment based on twenty-five thousand personally administered anesthetics, Romberger<sup>1</sup> states: "Time and space do not permit the expansion of this thesis upon the wonders and marvels of ether. In use one hundred years, administered by experts and tyros alike many millions of times, susceptible to a hundred and one adaptations and combinations, flexible almost beyond imagination in the hands of those experienced, it remains and probably will remain for many years to come our most universally useful agent. It is the one reliable age-old standard by which all other agents, methods, and results are judged."

From this statement—and from those of other leaders in the field of anesthesia—it may be concluded that ether is probably the world's safest—most adaptable—most widely used anesthetic agent.

Dr. E. R. Squibb pioneered in the production of anesthetic ether nearly a century ago. Since its inception the House of Squibb has followed his policy of making only one quality of ether—for anesthesia. Squibb Ether is the only ether packaged in copper-lined containers to prevent formation of undesirable toxic substances.

Squibb Ether is used in over 85% of American hospitals—in millions of cases every year. Such widespread use is evidence of the confidence which surgeons and anesthetists have in the ability of Squibb Ether to produce safe, satisfactory anesthesia.

<sup>1</sup>Romberger, Floyd, T.: *J. Indiana S. M. A.* 35:613 (Nov.) 1942.

*For literature address Anesthetic Division,  
E. R. Squibb & Sons, 745 Fifth Ave., N. Y.*

# SQUIBB ETHER

MADE, TESTED AND PACKAGED ONLY IN THE SQUIBB LABORATORIES

dium bicarbonate, chilling of the solution and saturation with carbon dioxide gas are necessary before filling to ensure an undecomposed solution after sterilization.

We come now to the ampulling of the solution. Obviously, the ampules must be clean. There are a number of fancy washing apparatus available, but the washer we employ is simple and can be constructed within the hospital. It consists of a U made of brass or galvanized pipe and fittings. One end attaches to a faucet by means of a union and from the other end projects a hypodermic needle, about 19 gauge by 2 inches long, passed through a hole in the pipe cap and soldered in place. In the U is a valve by means of which the water can be turned on and off. Entering this U, between the valve and the needle end, is a compressed air line with a valve for control. By simply placing the neck of the ampule over the needle and opening the water valve a strong stream of water sprays and washes the inside and the subsequent injection of compressed air by closing the water valve and opening the air valve expels the water.

As in the case of washing equipment, there are several types of automatic filling devices. However, for our purpose we find that filling through a needle, or a fine glass pipette in some cases, connected by rubber tubing to a Kelly infusion bottle reservoir supported high on a ring stand, is perfectly satisfactory and quite efficient. For small quantities of small ampules filling by means of a large hypodermic syringe and needles is sometimes preferred.

#### Gauging Amount of Solution

In filling the ampules a measured quantity slightly more than will be the dose required is put into the first one or two to be filled. The remainder of the lot is filled by comparison with the measured ampules.

Seals can be made by heating the ampule tip sufficiently to cause the glass to melt and run together. Again, the properly heated tip of the ampule can be drawn out to a seal by using a heated glass rod. To make a good uniform job of sealing requires practice. A Bunsen burner flame is not hot enough to seal most ampules and is not efficient for sealing even the smallest of ampules. A more intense heat is necessary and

we use a blast burner with a mixture of natural gas, oxygen and compressed air as the fuel.

With the burner adjusted to produce a strong pointed blue flame about 3 or 4 inches long and inclined upward at an angle of 45 degrees, the body of the ampule is held with the thumb and first two fingers and the tip of the ampule is dipped into the apex of the flame. In this position it is rotated to get even heat around the tip and ensure a uniform constriction of the molten glass and a perfect seal. Practice alone will teach the length of time the ampule must remain in the flame.

If the ampule tip remains in the flame too long the heated expanding air above the solution will blow open the seal the moment it is made. Too short a time in the flame will result in an imperfect seal. Usually the constricting lumen, when it gets quite small, appears as a black line in the white-hot molten glass. If the ampule is removed from the flame the moment this line disappears, the seal will be perfect.

Larger ampules naturally require longer to seal than do smaller ones. With some practice it is possible to seal about 12 small ampules per minute, whereas only three or four 50 cc. ampules can be sealed in that time.

However experienced one may become in sealing ampules, there is always the possibility that a few in the lot may not be perfectly sealed. To test for "leakers" we use two methods, depending upon the size. Small ampules are immersed in a solution of methylene blue and the solution is heated. Upon cooling, the blue solution will be drawn into the leaking ampules making detection elementary. Larger ampules are first inspected with a 500 power lens, then autoclaved in an inverted position. In this position imperfectly sealed ampules are evacuated upon heating.

Most of the solutions we manufacture in ampules can be sterilized by autoclaving at a pressure of 20 pounds for twenty minutes, or a temperature of about 250° F. However, this degree of heat does decompose some solutions and in such cases lower pressures and times are employed. When autoclaves are not available, equivalent temperatures can be obtained by using boiling solutions of various chemicals. As an

example, a saturated solution of sodium chloride will boil at the same temperature produced by 15 pounds' pressure in an autoclave. Breakage does occur during sterilization, but with a good grade of ampules this factor is practically negligible.

After sterilization, the ampules must be cultured for sterility. This can be done by following the procedure outlined in the United States Pharmacopoeia. At the Cincinnati General Hospital samples from each batch are sent to the central laboratories where the culturing is done. Until a written negative report is returned to the pharmacy by the laboratory, the ampules are not issued for use. Upon receipt of a negative report each ampule receives a printed label bearing the control number for each particular lot.

#### Wide Variety Can Be Made

Some idea of the variety of ampules we make is given by the following list:

Koch's tuberculin  
Bovine tuberculin  
Gentian violet  
Pontocaine  
Sodium bromide  
Calcium gluconate  
Coramine  
Phenolsulfonphthalein  
Chaulmoogra oil  
Atropine sulfate  
Caffeine and sodium benzoate  
Metrazol  
Physostigmine  
Sodium citrate  
Distilled water  
Morphine  
Magnesium sulfate  
Ephedrine  
Thiamine hydrochloride  
Pilocarpine  
Methylene blue  
Sodium bicarbonate  
Sodium salicylate  
Calcium chloride  
Procaine  
Congo red  
Camphor in oil  
Adrenalin and ephedrine

This list only demonstrates the immense possibilities for hospital pharmacists to make their own ampule solutions. At the Cincinnati General Hospital ampules have been a part of the regular routine work for some twenty or twenty-five years. The work has continued to expand both in variety of ampules and in the number of units produced.



## "ALL OUT OF STEP BUT JIM!"

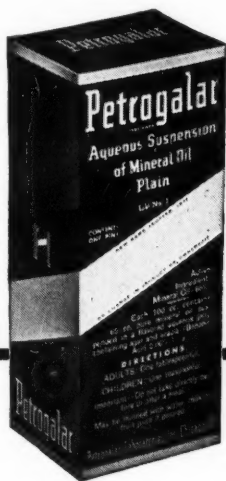
● Intelligent Army supervision soon corrects the errors of new recruits. But in civilian life errors in personal health habits usually must be corrected by the physician.

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# SAFETY and SAVINGS *in dried and frozen* PLASMA

**I**T NOW appears to be clearly proved that plasma can replace whole blood injections in many conditions in which, hitherto, the latter was believed essential. Particularly is this true in instances in which speedy treatment is indicated in shock and in states in which blood proteins are lowered. Indeed, pooled plasma requiring no costly delay or other laboratory work, such as the Wassermann test, is vastly superior in many ways to whole blood. Moreover, in many hospitals plasma now is employed four times as frequently as is whole blood—the blood bank now dispensing 80 per cent plasma to 20 per cent whole blood, a complete reversal of former figures.

Pooled or diluted plasma obtained by an aseptic technic from citrated blood and promptly administered to a patient is an ideal therapeutic agent and in the vast majority of cases will cause no reaction. The disadvantages of employing citrated normal human plasma (U.S.P. XII) consists principally of the possibility of bacterial contamination, the formation of protein particles in the solution which may even endanger the life of the patient by lodging in the tissues of the lungs and the impossibility of transporting it for any considerable distance.

## Liquid Plasma Stored Safely

Even so, liquid plasma taken under ideal aseptic conditions, filtered before using and kept at a steady temperature of 4° C. can be safely administered after from six to nine months' storage (Newhouser and Losner, Conn. S. M. J. 6:14, [Jan.] 1942). Strumia and McGraw (J. A. M. A. 118:427, [Feb. 7] 1942) believe that greater safety accompanies the use of frozen or dried plasma. To ensure a safe material the pooling of from eight to twelve lots in order to lower an occasional

**JOSEPH C. DOANE, M.D.**

high isoagglutinin content is considered desirable.

In the hospital that does not find available proper laboratory and personnel facilities for the preparation and preservation of liquid plasma, dried or frozen plasma offers many advantages. Dehydrated plasma is purchasable and requires the addition only of a menstruum or liquid in proper amount to become immediately available (less than three minutes) when an emergency arises.

There are many splendidly organized and equipped plasma stations in the hospitals of this country. Some employ liquid plasma, a lesser number use frozen plasma and probably a still smaller number have adopted the desiccation technic. As early as 1895 Rosenau attempted to dry human serum but he and those who followed him in this effort found that in the drying changes occurred in the chemical nature of the product that produced unfavorable reactions in the patient.

Since then many technics have been devised in an effort to desiccate human plasma without changing its chemical or physical properties. The one that seems most practicable now consists of rapidly freezing the plasma after it has been separated from the corpuscles by centrifugation. The frozen plasma then is subjected to a vacuum process that produces dehydration.

The dehydration of plasma may appear to be simple, but proper equipment for freezing and dehydration is expensive and trained personnel is difficult to find. In the smaller hospital, unless it serves as the plasma center of a large community, the purchase of such expensive apparatus is not wise.

Hence, dried plasma is expensive

to produce. Its greatest advantage is its stability over a long period of time. But to meet U.S.P. specifications is difficult and to my knowledge no inexpensive drying machine of a size suitable for one hospital has been devised. It is definitely my recommendation then that no individual hospital undertake the dehydration of plasma. At the present time, unless a large need exists or is likely to develop, frozen plasma may be the choice in a large hospital.

The United States Pharmacopeia now recognizes plasma in its three physical forms. A definite expiration date on liquid plasma ideally kept has been set at about a year; on dried plasma at five years. No such period has been set for frozen plasma.

The U.S.P. XII directs that dried plasma must not contain more than 1 per cent moisture. It has a light yellow or cream-like color. Microscopically it is honeycomb-like in appearance and does not fuse or pack. Dried plasma should not be exposed to excessive heat.

When dried plasma is marketed, commercially powdered plasma equivalent to 250 cc. when restored by adding 250 cc. of pyrogen-free distilled water is supplied in one vial and the water in another. The container must be flame-sealed of good quality glass and so constructed that the vacuum will draw the diluent into the container when being prepared for use.

## Freezing Preserves Prothrombin

When plasma is preserved in the liquid or powdered state there is a definite loss of prothrombin (coagulation factor) and complement (immunity factor). In the frozen state there is almost complete preservation of both prothrombin and complement. Plasma maintained in a frozen state and then thawed is almost identical with the original plasma.

Both the dried and liquid plasmas are purchasable. They are not inexpensive but in the long run it is more advantageous for many hospitals to purchase them from a high grade biological house. It is wise always to have an emergency supply of dried plasma on hand. Thus, even though electricity was cut off and ice boxes and freezing machinery stopped functioning plasma would still be available. In the small town hospital, dried plasma will fill an important need.



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# NOTES AND ABSTRACTS

Conducted by Carl C. Pfeiffer, M.D., F. F. Yonkman, M.D.  
Arnold J. Lehman, M.D., and Harold Chase, M.D.

## Drugs Producing Psychoses

In retrospect, the progress of medical science has usually awaited the discovery of an easy and sure means of reproduction of a disease entity. Once the cause of syphilis was discovered by Schaudinn and the disease transmitted to rabbits, effective drugs to cure syphilis were only a matter of further painstaking research. In like manner, but after a longer period of research, the discovery by von Mering and Minkowski (1890) that the removal of the pancreas produced diabetes started the long and hard research trail to the final discovery of insulin by Banting and Best in 1922.

We now have drugs which will produce in man and animals certain types of pharmacologic psychoses that are similar to human psychoses and which, when adequately studied, may give clues to the altered metabolism of the psychotic patient.

**Toxic Psychosis:** Alcohol in excess and when used over a long period of time is known to produce manic insanity in which delusions and hallucination play an important part. Whether the patient has maniacal delusions or Korsakoff's psychosis, the mental state cannot be ascribed directly to the alcohol but must be due to a mixed state of avitaminosis, dehydration (with shifts in water balance) and general malnutrition resulting from the habits of the chronic imbibitor.

This can be said with certainty, since we know that large doses of alcohol in the well-fed individual and in the experimental animal result only in depression and anesthesia. Experimentally, then, alcohol cannot be relied upon to reproduce any psychosis for experimental study.

Bromides in excess will produce various degrees of intoxication in man, which is manifested as the psychotic state. Some degree of bromism is present in from 2 to 10 per cent of all admissions to psychopathic hospitals. Here, as in chronic alcoholism, the mental symptoms are varied and may range from mental dullness to mania or coma. No analogous state can be produced in the experimental animal even though bromides are given to the point of extreme edema.

Miscellaneous drugs that produce the psychotic state are the sulfonamides, dilantin and atropine in overdosage. The mental changes produced by the sulfa drugs are usually mild and completely

reversible when the dosage level is decreased. They may take the form of a persistent euphoria or the grandiose generosity of the paretic. This may become economically dangerous in the ambulant patient.

The delirium caused by atropine is seldom seen except in poisoning. The excitement of atropine can be reproduced in experimental animals, while the toxic effect of sulfa drugs in overdosage in dogs is manifested only by decerebrate rigidity. Dilantin, a recent addition to therapeutics used to control epilepsy, has also been reported occasionally to produce psychoses in sensitive individuals. Discontinuance of therapy results in a prompt disappearance of these toxic symptoms.

**Bulbocapnine:** Catalepsy can be produced in either man or experimental animals by the oral administration of bulbocapnine, which is extracted from the tubers of *Corydalis bulbosa* (Dutchman's breeches). Because of the steady effect of this alkaloid, it has been used sporadically since 1526 for the control of muscular tremors. While chemically similar to apomorphine, it has none of the emetic qualities of the latter.

Bulbocapnine has failed clinically because of the uncertainty of the effects on oral dosage which is high—usually 200 mgm.—at a single dose. Academically, it has been studied extensively to provide clues to the physiology of the cataleptic state. Molitor of Merck's has shown that bulbocapnine acts on the deep centers of the brain stem in producing the typical catalepsy.

While bulbocapnine has been suggested as a preanesthetic depressant, scopolamine with greater depressant action has proved more effective. It is still being used by experimenters to study a specialized type of catalepsy in the experimental animal.

**Mescaline:** By far the most promising of all drugs that produce psychotic states is this rather simple alkaloid which is extracted from the flowering tops of the mescal cactus that grows in the American southwest desert region. The roasted flowers are known as peyote buttons and are chewed by the young manhood of various Indian tribes to prove apparently that they have come of age and are now warriors.

While absorbing the drug the users describe beautiful colored visions and hallucinations. One Indian chief told

an investigator that his tribe used peyote as the white man uses aspirin. Since it has narcotic action and probably some analgetic action, this use is probably justified.

Surprisingly, while the American Indian learned to use an American plant, the only scientific studies on the active alkaloids have been made in England and on the continent of Europe. Chemically, mescaline is 3, 4, 5 trimethoxy phenyl ethyl amine. It has been prepared synthetically by chemists in both England and Switzerland. Since mescaline is chemically similar to the pressor amines, one might expect some such pharmacologic action.

Actually, the compound, because of the three methoxy groups, has little pressor action but has instead a depressant action on the central nervous system. The most extensive pharmacologic studies have been made by Grace, working in England. He found that mescaline if given intravenously produced a slight drop in blood pressure. Motor paralysis occurs because of subcortical depression, and death from overdosage occurs as a result of central respiratory failure.

G. T. A. Stocking, also working in England, has published the most extensive clinical studies of mescaline psychosis. In proper dosage of from 100 to 500 mgm. administered orally, Stocking claims that almost every degree of abnormality that we describe as psychotic behavior may occur in the experimental subject. Fortunately, the effect is completely reversible—the psychosis starts in half an hour and lasts from eight to twelve hours only.

The subject's lips and tongue become dry; his skin is at first flushed and then pale and dry. The urine is scanty and highly colored. The eyes are bright with an increased pupil diameter. There is marked dulling of the pain, heat and proprioceptive senses and the deep reflexes are increased. Spatial orientation and discrimination are lost. Many of the colored visions or hallucinations described by the patient are apparently distortions and prolongations of after images.

The hallucinations are associated with the occupation in that a student of the classics was beset by mythological monsters, while an airplane pilot found himself wandering in a city composed entirely of giant engines. Auditory hallucinations may take the form of voices speaking strange or musical sounds or the subject's thoughts may become separated and talk back to him.

The patients have occasionally described their bodies as lifeless or rubbery, with arms and legs out of all proportion. The investigator's face seems exaggerated and mocking. Delusions of grandeur or feelings of persecution are



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common, or the subject may describe himself as having lived in a private world in which time is so distorted that 100 years pass in a few hours. Synesthesia may occur in which the senses are so mixed that the subject describes music as pulsating rhythmic colors, or visual stimuli as beautiful music.

While further study of mescaline may aid only in the elucidation of the altered physiology of the psychotic state, an alkaloid that is as simple as mescaline may also become the nucleus for beneficial therapeutic effects when the molecule is changed by the research chemists.

—CARL C. PFEIFFER, M.D.

## CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

### Eliminating Cast Odors

One of the few aspects of the Orr treatment of osteomyelitis on which there is universal agreement is the unpleasantness of the odor that is likely to develop in the cast. This putrid odor is neither necessary nor beneficial, according to Wallis and Dilworth (*Journal of the American Medical Association*, Oct. 24,

1942) who believe it to be due to putrefaction by anaerobic bacteria accidentally implanted in the wound. The proteolysis is initiated, at least in part, by the autolysis of devitalized tissue. Proceeding on this assumption and on the well-known principle that bacteria that can utilize both carbohydrate and protein will attack the former by preference when the two chemicals are present simultaneously, the authors thought it logical to implant a sugar in the wound.

Gauze soaked in sterile 18 per cent lactose solution in distilled water is placed directly upon the wound and then covered with dry dressings so that the plaster cast does not come into direct contact with the wet dressings. The plaster cast is, of course, applied in the usual manner.

In five of the six cases in which this treatment was used, there was no odor for periods up to six weeks. After the seventh week a slight, partly ammoniacal and partly foul odor was detected, but this only in the immediate vicinity of the cast.

Finally, the authors suggest that their treatment might be profitably applied to putrid ulcerating malignant tumors and other nonosseous lesions.—SIGMUND L. FRIEDMAN, M.D.

### Rehabilitating the Tuberculous

This article consists of a statistical review of the medical experience of a group of 964 patients with pulmonary tuberculosis as published in an article by Louis E. Slitzbach, M.D., "Medical Aspects of the Rehabilitation of the Tuberculous, the Experience of a Quarter Century With 964 Patients at Altro Work Shops," *American Review of Tuberculosis*, November 1942.

These patients were admitted for a temporary rehabilitation course at the Altro Work Shops, a medically controlled garment factory in New York City, during the years 1915-1939. The longest period of follow-up medical observation was twenty-five years and the shortest, one and one half years. Ninety-seven per cent of the patients were traced five years; 92 per cent could be traced ten years.

In the earlier period of operation of the workshop, 1915-1929, only 6 per cent of the patients received collapse therapy before Altro admission; in the later period, 1930-1939, 52 per cent had some form of collapse therapy. Four out of five patients had moderately advanced or far advanced lesions on entry to the workshop. Thirty per cent of the work-

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ers had no record of positive sputum before admission. Fifty-five per cent had a positive sputum which had been successfully converted to a negative sputum before admission. Fifteen per cent still had a positive sputum on admission.

The percentage of patients with successful sputum conversion before Altro admission rose from 38 per cent in 1915-1929 period to 69 per cent in the 1930-1939 period. The percentage of patients admitted to the workshop with a positive sputum fell from 25 per cent in 1915-1929 to 6 per cent in 1930-1939.

At the end of ten years after discharge from Altro, 87 per cent of the patients with minimal lesions and 86 per cent of the patients with moderately advanced lesions had survived. For patients with far advanced lesions, the survival rate was 63 per cent. Patients with a negative sputum at admission to the Altro Work Shops were alive in 84 per cent of instances at the end of ten years. Fifty-four per cent of those admitted to the workshop with a positive sputum survived at the end of ten years. For the entire experience the mortality of Altro patients was about twice that of the general population of the same age and sex composition.

At the end of ten years 86 per cent of the patients with minimal disease at Altro admission escaped recurrence or breakdown; 70 per cent of the patients with moderately advanced lesions and 45 per cent of the patients with far advanced lesions had no recurrence. In the group of patients who had a negative sputum when they were admitted to the Altro Work Shops (85 per cent of the total number), from 86 to 93 per cent of their first fifteen years after Altro discharge were spent as "well years."

These figures indicate that the Altro scheme is clinically sound, for the record of these patients is satisfactory as measured by their subsequent mortality, their recurrence rates and the time they lost as a result of these recurrences. As a nation at war our tuberculosis problem will assume increasing importance. Rehabilitation can be a most important adjunct in handling it. Expansion of this inadequately developed portion of anti-tuberculosis work is feasible, practical, necessary and sound—E. M. BLUESTONE, M.D.

#### Financing Asthma Treatment

In a report in the Journal of Allergy, for September 1942, Gaillard summarizes a five year study on some of the financial and social aspects of asthma in approximately 600 adult and pediatric patients who have been attending the clinics of the New York Post-Graduate Hospital.

For purposes of diagnosis, treatment, and correlation, the cases were divided into three groups: the sensitive, the

infective and the mixed. The cases were then classified with respect to their attendance at the clinics. Treatment was discontinued in 11.6 per cent of the cases for various reasons; 4 per cent of the total discontinued because they felt they had not improved, but this was exactly balanced by the 4 per cent who stopped because they felt they had been cured.

The largest average annual cash outlay per patient for the treatment of asthma was \$63.80 and was made by the adult infective asthmatic; the next largest sums were \$36 and \$37, spent by the adult sensitive and mixed groups.

This corresponds with the clinical experience of allergists who have found that the sickest and the most difficult to treat successfully are the members of the adult infective group. The smallest outlays were made by members of the pediatric groups among which the cost varied little with the classifications (from \$23.70 to \$28.03).

The greatest amount of money spent for medicine was in the adult infective group: \$18.30 per patient. This was almost double the amount spent by the mixed asthmatic and more than triple that spent by the sensitive patient.—SIGMUND L. FRIEDMAN, M.D.

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# NEWS *from* WASHINGTON

## Bills Affecting Social Security Introduced Into New Congress

With the opening of the new Congress came a rush of new bills affecting hospitals and Blue Cross plans. In his annual message, President Roosevelt appeared to be sufficiently vague so that he could press for widening the Social

Security Act or could drop the matter.

Both party caucuses adjourned without any action on this issue, but a number of bills have already been introduced. One of the most comprehensive to date was introduced by Senator Green

of Rhode Island on January 11. The bill, S. 281, would expand the Social Security Program with provisions for insurance benefits for workers permanently and totally disabled, for hospitalization benefits, old age assistance and aid to dependent children. Senator Green says his bill may not go far enough because it does not include, among other things, health insurance. It would extend coverage to all important groups of workers now excluded. Special provisions are designed to protect the benefit rights of men in the armed services.

It has been reported that Senator Wagner of New York will introduce the official administration measure to amend the Social Security Act. A report of the National Resources Planning Board, which has been on the President's desk for some time, is said to recommend a complete governmental health service as one item in a long list of projects.

Copies of Sir William Beveridge's report were made available in this country in January. This report is said to have influenced markedly many of those in federal service. In his recommendations, Beveridge says that "medical treatment covering all requirements will be provided for all citizens by a national health service organized under the health departments and postmedical rehabilitation treatment will be provided for all persons who are capable of profiting by it."

In the detailed discussion of health and rehabilitation service, however, his recommendations seem to permit the continuance of the voluntary contributory systems, which he says have had a remarkable growth. While advocating compulsory universal health insurance, the report states that these "proposals are provisional only, subject to review, in the light of the further enquiry suggested, in which organization and finance can be dealt with together." He suggests that a further investigation of the situation be made.

Philip Murray, president of the Congress of Industrial Organizations, on January 19 presented a labor statement calling for "a national health program that will ensure the people medical care on a federal basis and supply free medical care for those who cannot afford insurance."

House Resolution 370 seeks to extend federal old age benefit provisions of the Social Security Act to certain nurses in respect to their employment outside of religious, charitable and other nonprofit institutions.

Representative Coffee of Washington has stated that he will introduce again his bill to provide for federal assistance in meeting the costs of medical care for certain classes of government charges.



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The Michigan Alkali Company grew to be one of the great basic chemical companies of the world, manufacturing a wide range of products serving more than fifty different industries.

The J. B. Ford Company developed into the world's largest manufacturer of specialized cleaning materials, and an important factor in promoting sanitation and safeguarding the health of America.

The company controls warehouse facilities strategically located at approximately 200 points throughout the country.

### **Consolidation a Logical Step**

On January 1, 1943, these companies were consolidated, still under the

same family ownership, to form the Wyandotte Chemicals Corporation.

This consolidation is a logical recognition of the close relationship which has existed between the companies for many years.

Management and personnel will remain the same, but the consolidation will offer an opportunity for even greater service to our customers.

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Wyandotte Chemicals Corporation will continue to have one of the best distribution systems in the United States—making all Wyandotte products more readily available, to smaller as well as larger consumers.

Combining the technical staffs of the two companies will now make it possible to bring a wider range of expert technical service to Michigan Alkali and The J. B. Ford customers everywhere.

The enlarged research laboratories may be counted upon to develop

important new products to meet the needs of war and post-war conditions.

And by the complete integration of the ownership of raw material sources and control of manufacturing and distribution in the one company, Wyandotte Chemicals Corporation will be able still further to enhance the *quality* and *value* for which Wyandotte products have long been noted.

Contracts and commitments of Michigan Alkali Company and The J. B. Ford Company in force at the end of the year 1942 will be carried out without interruption by the Wyandotte Chemicals Corporation, and customer contacts will be maintained without interruption by the Michigan Alkali Division and the J. B. Ford Division of the consolidated sales departments.

It is our sincere intention to continue to develop and manufacture to the best of our ability products which help the nation in wartime and which will contribute to a fuller life when peace is won.

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FIRST AVENUE AT 44TH STREET, NEW YORK, N. Y.



## Health Equipment and Supplies Put Under Price Regulation No. 188

WASHINGTON, D. C. — Price control was extended recently to several items of particular interest to hospitals. A uniform mark-up of 20 per cent of the selling price on jobbers' sales of woolen or worsted apparel fabrics to religious institutions and their members for ecclesiastical use was provided in an order of January 15.

Corn prices were controlled by a temporary sixty day order effective January 13.

Health equipment and supplies were on January 13 transferred from other price control measures and brought under the control of Maximum Price Regulation No. 188, which establishes manufacturers' maximum prices. Specifically excluded, however, were drugs, chemicals and medicines (except when packed in first-aid kits). All repair parts and sub-assemblies especially designed for any health supply item are now brought under the regulation unless previously covered by some other price regulation.

Maximum prices on new "war model" wood-framed coil and flat bedsprings were announced December 29.

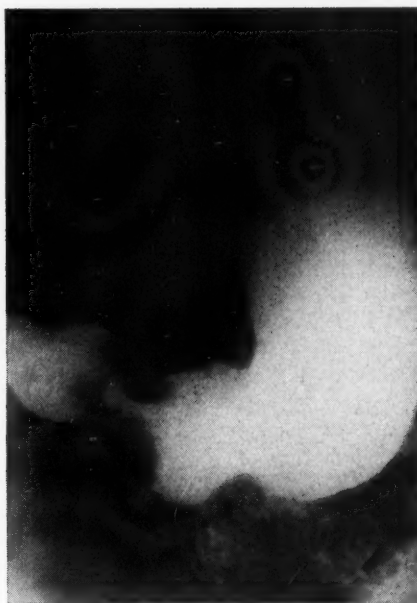
## Hospitals Get Steel Under Controlled Materials Program

WASHINGTON, D. C. — The Controlled Materials Plan has already begun to function for hospitals. The schools, hospitals and institutions branch has been allotted for the first quarter of 1943 1219 tons of carbon steel and 171 tons of alloy steel. Effective January 6, PD-1A applications requesting steel for fabrication of items for hospital use will be routed to the hospital branch of the Governmental Requirements Division.

According to Everett Jones the allotment will be analogous to having a bank account and drawing checks on the deposit. With each authorization for withdrawal from the allotment of steel, the deposit will shrink. When it is all used up, no more steel will be available for that quarter. The planning and research branch will keep a careful check on all end product divisions and advise as to the amount of steel consumed.

Ninety per cent of the materials is to be rated AA-3 for production and AA-2X for maintenance and repair. If ratings higher than AA-3 or AA-2X are shown on the first quarter applications, these higher ratings may be assigned in the same proportion as disclosed on the first quarter applications. The remaining 10 per cent of the quantities authorized for each product classification is to be rated AA-4.





## WHEN THE DIAGNOSIS IS OBSCURE

To facilitate fluoroscopic and radiographic examinations of the hollow viscera and other organs, several Merck contrast media are available. Their variety and excellent quality afford consistently satisfactory results.

Because of the meticulous care with which they are manufactured, and the rigid laboratory control to which they are subjected, Merck radio-paque preparations are dependable aids in making a diagnosis.

### FOR CHOLECYSTOGRAPHY

#### IODOPHTHALEIN SODIUM MERCK

Disodium salt of  
tetraiodophenolphthalein.

BOTTLES  
3.5 Gm., 25 Gm., 100 Gm.,  
500 Gm.

### FOR GASTRO-INTESTINAL RADIOGRAPHY

#### SKIABARYT

Special barium sulfate prepara-  
tion containing tragacanth.

NOTE: Two forms are available:

1. For oral use, flavored.
2. For rectal use, unflavored.

TINS, 1 lb., 5 lb., 25 lb.

#### GELOBARIN

Special barium sulfate cream  
which ensures stable suspensions.

BOTTLES, 5 Kg.

#### BARIUM SULFATE MERCK

Highly refined form of barium  
sulfate.

CARTONS, 1 lb., 5 lb.,  
25 lb. drums

### FOR RETROGRADE PYELOGRAPHY OR UROGRAPHY

#### SODIUM IODIDE MERCK REAGENT

Refined sodium iodide which  
exceeds U.S.P. requirements.

BOTTLES  
1 oz., ¼ lb., 1 lb., 5 lb.



MERCK & CO., Inc. *Manufacturing Chemists* RAHWAY, N. J.

## Hospitals' Request to Purchase Meat on Quota-Exempt Basis Is Rejected

WASHINGTON, D. C.—The request of voluntary hospitals for authority to purchase meat on a quota-exempt basis has been rejected, according to a letter of January 16 from Harold B. Rowe, director of the food rationing division of O.P.A., to James A. Hamilton, president of the A.H.A.

Mr. Rowe states that "Section 1407.912 (a) (4) of the meat restriction order carries no implication that private hospitals are less important than public in-

stitutions or that there is any basis for different treatment of the inmates. The basic distinction is not between public and private institutions, but between public institutions that do and those that do not purchase upon the basis of competitive bids.

"Under Restriction Order No. 1, no public institution purchasing upon the basis of competitive bids could possibly hope to receive bids in the absence of quota exemption since slaughterers have

no surplus and, hence, no reason for bidding. Private hospitals are not normally required to purchase by competitive bidding. They are at liberty to purchase in the open market and, therefore, do not require the special treatment given to public institutions that purchase upon the basis of competitive bids."

Mr. Hamilton stated to Mr. Rowe that certain slaughterers have refused to sell controlled meat to voluntary hospitals on the grounds that the restriction order forbids such sales and that other slaughterers have informed such hospitals that they are permitted to sell them controlled meat only in the percentages to which their civilian deliveries are restricted, for example, 70 per cent for beef.

In answer, Mr. Rowe declared that both these contentions by the slaughterers are unfounded. "The order does not prohibit deliveries to private hospitals nor does it restrict such deliveries to any fixed percentages of their 1941 purchases. Within their civilian quotas, slaughterers may distribute controlled meat as they see fit. The order does not allocate civilian quotas among elements of the civilian population. This responsibility remains with the meat industry."

Mr. Rowe advised any hospital having difficulty in obtaining its minimum requirements to make its needs known to all slaughterers and suppliers in the area, telling the number of meals served per week and minimum meat requirements for this purpose. He asserts that the industry has for the most part supplied the requirements of hospitals as stated to it.

In conclusion, Mr. Rowe states that any enlargement of the "exempt purchaser" category to include nonmilitary personnel "would make inroads into the supply reserved for our armed forces and fighting allies."



**If they COULD.....**

**they'd look at it a dozen times a day**



THEY'D NEVER want to stuff it deep down under things in bureau drawers . . . . . and only see it accidentally . . . . . sometimes.

If they could . . . they'd want to see it a dozen times a day . . . for years . . . . . and each time know the pleasant tireless glow of their own small private miracle . . . . .

That's why we have such things as Duplex Frames for holding our Hollister copyrighted Birth Certificates. They're as handsome, as clean cut as the fine certificates they frame . . . . . they're made so Moms and Dads may see *both* important sides of their child's first document . . . . . and if *you* gave or sold them they'd help to make yours a *famous* hospital in *every* home you serve . . . . . and you could note that feeling . . . . . soon.

FRANKLIN C. *hollister* COMPANY

538 WEST ROSCOE STREET

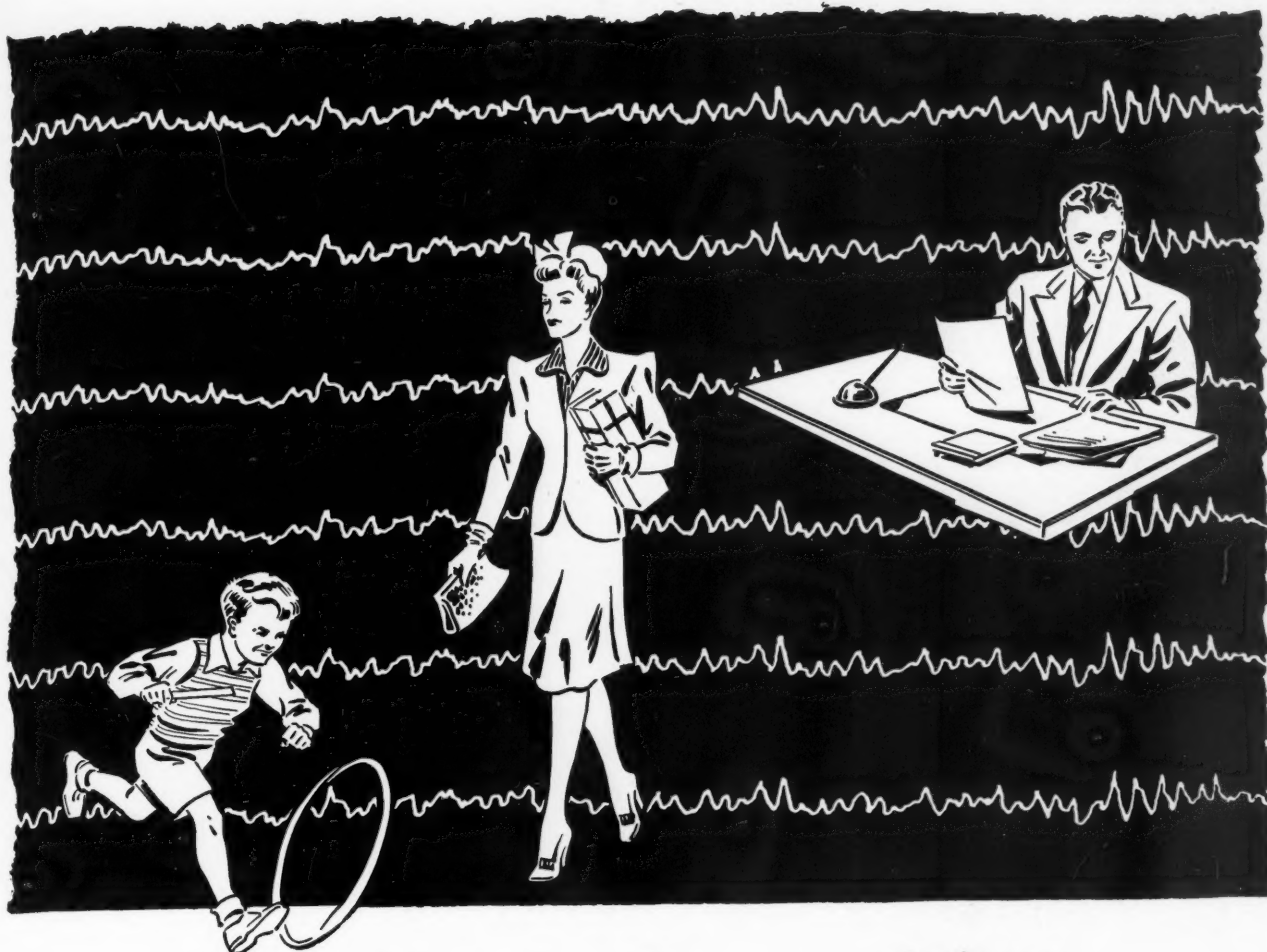


CHICAGO

## Gas, Oil Heaters Restricted for War Projects in 1943

WASHINGTON, D. C.—Gas-fired and oil burning water heaters will be manufactured in 1943 only for use in war housing or other war projects. Limitation orders issued December 21 restrict production and limit the amounts of metal and metal alloys to be obtained by the industry. Production of metal tank jackets and metal tank supports is suspended and the installation of metal tank jackets is prohibited except for minor exceptions.

Civilians, therefore, will get heaters only out of present stocks. The stocks are large at present and necessary replacements can still be made. Civilian consumers are cautioned by W.P.B., however, to use coal rather than gas heaters because of the present critical situation in the supply of gas.



## *The Moving Finger Writes*

OF MORE NORMAL, HAPPIER PEOPLE

**T**HE oscillating "finger" of the electroencephalograph, recording abatement of abnormality of brain waves, tells but a part of the story of epilepsy treatment with Dilantin<sup>†</sup> Sodium. Fewer and less severe seizures, more normal social and economic life have been observed in many thousands of epileptic patients receiving this modern anticonvulsant.

Dilantin Sodium possesses "many advantages" in the control of epileptic convulsions.<sup>1</sup> For one thing it is, in many cases, superior in anticonvulsant effectiveness to phenobarbital or bromides, and—highly important—it is practically non-hypnotic. The inclusion of Dilantin Sodium (diphenylhydantoin sodium) in the new U.S.P. XII speaks volumes for its therapeutic importance.

<sup>†</sup>TRADE-MARK REG. U.S. PAT. OFF.

**PARKE, DAVIS & COMPANY**  
DETROIT, MICHIGAN



**KAPSEALS**

# **DILANTIN SODIUM**

A product of modern research offered to the medical profession

1. Palmer, H. D. & Hughes, J.: *The Penn. Med. J.*, Aug. 1942



# Only Laboratory Equipment Can Be Obtained Under L-144, Jones Warns

By EVA ADAMS CROSS  
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—Many hospitals have been using Order L-144, as amended, which applies to laboratory equipment to make application for many other items, Everett W. Jones pointed out recently, and the practice must be stopped. Laboratory equipment is defined in the order to mean material, instruments, appliances, devices,

parts thereof, tools and operating supplies for laboratories or for use in connection with operations usually carried on in laboratories, not including second-hand items.

Items to be acquired under this order are limited to a value of \$50, except on authorization of the director general for operations. Purchases authorized on the

basis of applications made on Form PD-620 will be assigned an AA-4 rating.

The purposes for which certification is given are clearly indicated in the order: research, production, analysis or testing of materials; replacement, to the extent necessary, of essential existing equipment in laboratories affecting the public health and in federal, state, county and municipal laboratories; repair parts and operating supplies to the extent necessary for the maintenance of existing essential equipment and activities in laboratories.

## Production of Floor Machines Prohibited After April 15

WASHINGTON, D. C.—Production of floor sanding, finishing and maintenance machines after April 15 has been prohibited by the amendment on January 16 of Order L-222 and after February 15 fabrication of parts for these machines must cease. Assembly of new machines is prohibited after April 15. Production of industrial vacuum cleaners was also put under severe restrictions.

If a hospital can prove its need because of serious labor shortage or other severe handicap, it may file PD-722 with the W.P.B. If this application is approved, the manufacturer may then file an appeal with the Appeals Branch of W.P.B. for permission to manufacture.

Supplies that need replacement, such as brushes, drums or disks, can be produced without restriction. Sales, rentals and transfers of the following types of new equipment are prohibited unless authorization is given: drum type of floor sanding machines making an  $\frac{1}{8}$  inch path or wider; disk type of floor sanding machines making a 12 inch path or wider; floor finishing machines, and industrial vacuum cleaners.

## No Priority Needed on Tools

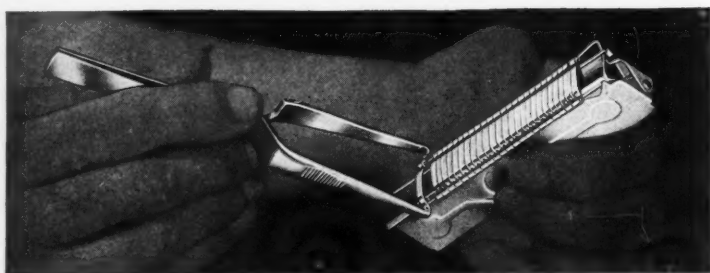
WASHINGTON, D. C.—The Hospital Branch of W.P.B. was advised December 31 that PD-1A applications for staple items of hardware and mechanics' tools in small lots need not be recommended for a preference rating. The reason given is that reasonable quantities of these items are regularly allowed to distributors and dealers in order to meet the need of the general public and, hence, are supplied without priority assistance. This ruling does not cover precision tools.

## Florida Hotels Now Army Hospitals

WASHINGTON, D. C.—The War Department announced December 17 the acquisition by lease of the Pancoast, Tower and Gulf Stream hotels, Miami Beach, Fla., for conversion into general hospitals for Army Air Forces.

## BOWEN-ADAMS WOUND CLIP RACK

The Bowen-Adams Wound Clip Rack should be used only with the improved Hegenbarth-Adams Wound Clip Forceps.



## ... AN AID IN CONSERVING WOUND CLIPS

As an aid in conserving the limited supply of wound clips now available, it has been suggested that a wire of clips of each size that you use be placed each on one of the Bowen-Adams Wound Clip Racks where they are ready for use and protected from damage. The wound clips not used during an operation will remain on the Rack and are ready for use for subsequent operations. In this way, the tendency to discard the unused portion of a Rack of clips is minimized.

B-2339/SS Bowen-Adams Wound Clip Rack, made of Stainless Steel. Each.....	\$ 2.00
Dozen .....	20.00
B-2323/SS New Hegenbarth-Adams Wound Clip Applying Forceps, made of Stainless Steel, self-retaining, clips do not fall out. Each.....	\$ 2.50
Dozen .....	25.00



Order From Your Surgical Dealer

**CLAY-ADAMS CO. INC.**

44 EAST 23rd STREET, NEW YORK, N. Y.



# Cretinism

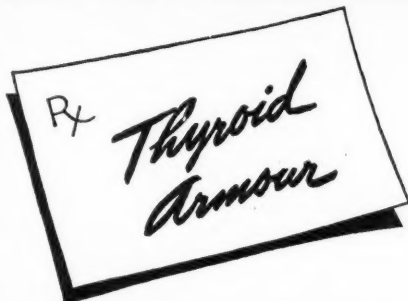


THE advent of thyroid medication has radically altered the prognosis of sporadic cretinism. And as a result, many individuals who would otherwise have been absolute losses to society have developed into useful citizens. Today, largely because of preventive medication, cretinism is less commonly encountered, and much more attention is being devoted to the *milder* and more common forms of thyroid hypofunction. These mild forms may have a diversity of manifestations and require considerable clinical study, metabolism tests and laboratory determinations for their recognition.

Ever since those early days when oral thyroid administration was in its infancy, THE ARMOUR LABORATORIES has been a leader in the preparation of medicinal thyroid. Armour scientists pioneered in developing methods for the preparation and standardization of thyroid substance for medicinal use. They co-operated with the pioneer clinicians and pathologists who were studying its therapeutic application. The Armour Laboratories was first to recognize the seasonal and regional variation in the natural iodine store of animal thyroid. It instituted a method of assaying and then blending the glands to fixed standards, and a method of choosing the select animal glands by geographic areas where a relatively stable proportion exists between thyroxin and the other organic iodine compounds.

Such methods of selection and blending are possible to The Armour Laboratories because it has available the world's largest supply of fresh raw material from which to choose.

Such methods insure to your patient a thyroid preparation of dependable, uniform potency whenever you specify "Armour" on your thyroid prescriptions.



*Have confidence in the preparation you prescribe  
— specify "Armour"*

Supplied in 1/10, 1/4, 1/2, 1, 2 and 5  
grain tablets and in powder.

**THE ARMOUR LABORATORIES, CHICAGO, ILL.**

Headquarters for Medicinals of Animal Origin

## Lumber Has Become Critical Material, W.P.B. Officials Warn Hospitals

WASHINGTON, D. C.—Lumber is a critical material, the Governmental Branch of W.P.B. warned recently. Some hospital officials feel that as long as whatever construction they want is to be made of lumber, their request should be granted. But an understanding of the lumber situation should immediately dispel such notions. There are timber resources to meet the requirements, both military and civilian, and there is enough sawmill capacity. How-

ever, the full use of the industry's productive capacity is severely handicapped by the high rate of labor turnover and the large number of separations.

In September, sawmills lost 12 workers out of every hundred. The same condition prevailed for most of 1942. A reduced output in the Southern Pine region accounted for the lower national output. Demand has been consistently in excess of production.

A record volume of lumber imported has helped to ease the supply problem and official restrictions on the use of lumber in construction have narrowed the demand. However, war construction

needs and various essential uses other than construction are likely to maintain demand at high levels.

## Burdette and Rees Are Named to Hospital Section of W.P.B.

WASHINGTON, D. C.—Samuel O. Burdette has been appointed chief of the service equipment maintenance and repair unit, hospital section of the Governmental Division, W.P.B. Mr. Burdette had previously served in the War Department and the U. S. Public Health Service. In his new capacity, Mr. Burdette handles applications for nonprofessional equipment, operating supplies and maintenance and repair materials.

Another recent appointment to the Governmental Division is that of Dr. H. M. Rees, chief of the professional and scientific equipment unit. Doctor Rees, formerly resident in pathology at Cleveland City Hospital and assistant to Herbert Hoover in the Relief Administration Mission to Poland, has in recent years been engaged in teaching and investment counsel work. In World War I Doctor Rees served as second lieutenant with the Third Division.



# SAVE TIME

## FOR PATIENTS AND OPERATING TEAMS

**...PLUS Convenience in Sterilizing Bone Plates, Screws and Twist Drills.** The combined advantages of the exclusive Zimmer Bone Plate and Screw Container have made it standard operating room equipment in hundreds of government

and private hospitals. Covered by U. S. Patents. Three complete outfits to choose from, including full set of Sherman type or plain pattern plates, screws and drills. These are available with or without the carrying case.

*The new S-M-O Stainless steel, proved to be inert and also the toughest material applicable for bone work, is used in Zimmer plates, screws.*

# Zimmer

**BONE PLATING CONTAINERS  
AND EQUIPMENT, WARSAW, IND.**



Catalog of informational material on complete line of Zimmer Fracture Equipment will gladly be sent on request. Coupon at right is for your convenience.

**ZIMMER MANUFACTURING COMPANY  
WARSAW, INDIANA**

Please send me your new catalog on complete Zimmer line.

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

## Official Orders

(December 15 to January 15)

**Cinchona Bark.**—This source of quinine and its derivatives is further conserved for direct antimalarial use by Order M-131, as amended January 9.

**Electric Motors and Generators.**—Purchase orders for electric motors and generators must bear preference ratings of AA-5 or higher under Order L-221, amended again January 15. The amended order provides a rating "floor" on orders for both electric motors and generators.

**Floor Sanding Machines.**—Order L-222, issued January 9, prohibits production after March 15 of floor sanding, finishing and maintenance machines. Production of industrial vacuum cleaners was also put under severe restrictions.

**Lumber.**—Order L-150-a, issued December 19, prohibits over-all sales of softwood plywood through wholesale and retail channels except on orders rated AA-5 or higher.

**Metal for Plumbing.**—An enlarged and revised Schedule XII of Order L-42, issued December 30, imposes further restrictions on the use of metal in the manufacture of plumbing fixtures.

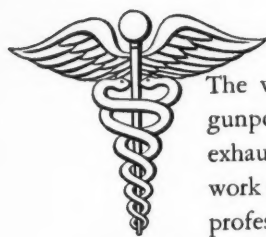
**Refrigeration.**—Order P-126, amended December 31, continues the use of high preference ratings for material needed for emergency servicing of refrigerating and air-conditioning machinery and equipment.

**Repair Priorities.**—Twelve regional directors of W.P.B. were authorized January 8 to approve, countersign and issue individual preference ratings for emergency repair up to and including AA-1.

**Vitamin C.**—Order M-269, effective December 15, places ascorbic acid, vitamin C, under allocation control.

**Water Heating.**—Interpretation 1, January 11, of Order L-185 explains that any heating appliances, including laundry stoves or laundry heaters, which have built-in coils for water heating or which have water jackets as integral parts of the appliances, are water heaters.





The whine of bullets, the smell of gunpowder, the paralyzing ache of exhaustion—these are all in a day's work for the members of the medical profession among our armed forces.

Wherever there is a life to be saved, in the heat of Africa or the cold of Alaska, they can be found toiling feverishly without thought of personal danger or fatigue. The story of their work at Pearl Harbor, Bataan, Corregidor and in the Battle of the Solomons will be numbered among the heroic deeds of history. America owes a deep gratitude to these warriors of mercy for

their valiant work on the battlefronts of the world.

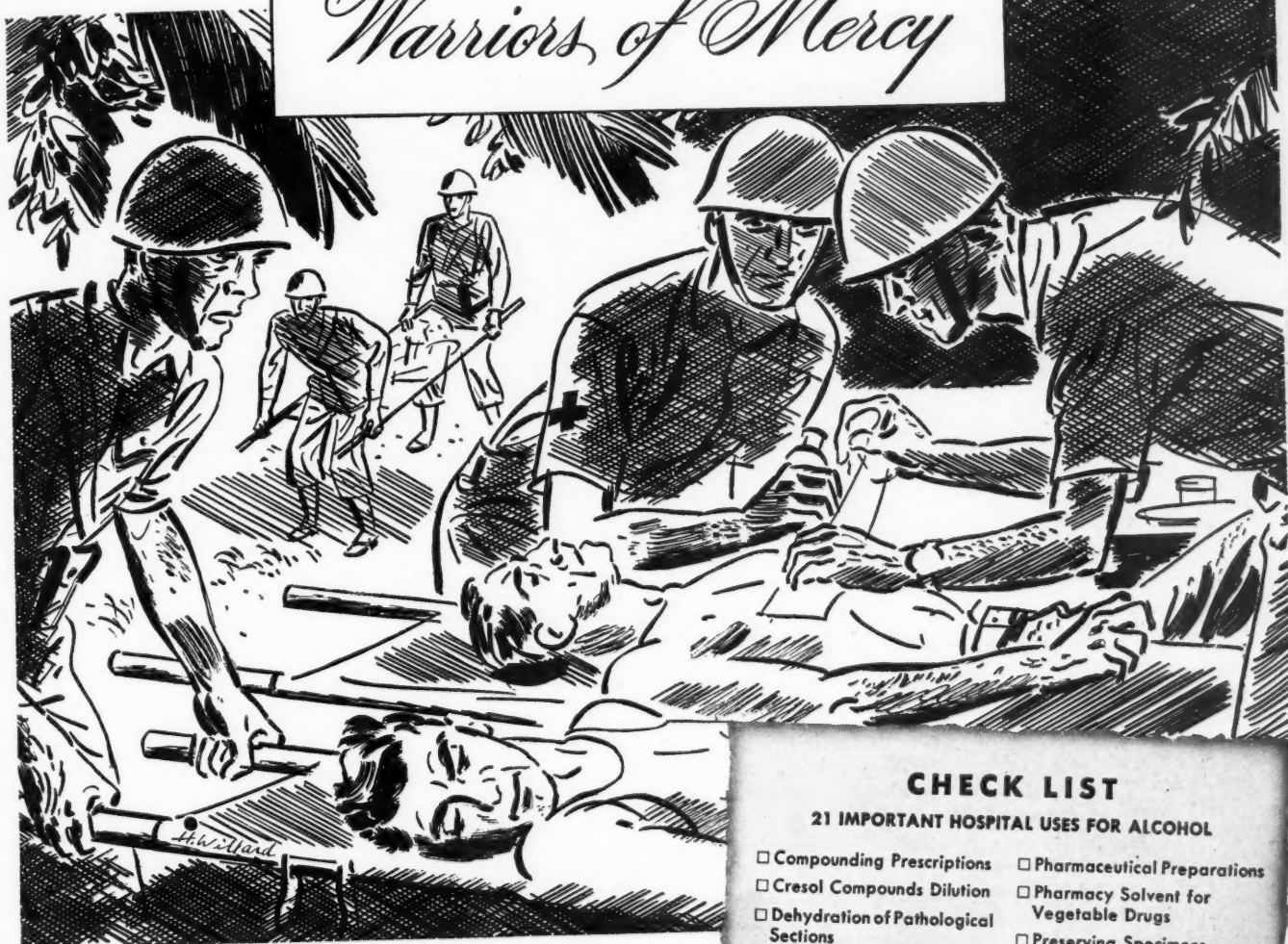
Aiding them in their ceaseless fight against death and disease are revolutionary advances in drugs and surgery unknown in World War I. Also playing an important, although less spectacular, part are such long-established medical aids as U.S.I. Pure Alcohol. The same high quality that has made U.S.I. Pure Alcohol the choice of leading hospitals throughout the country is now proving of equal value on the battlefront.

**U. S. INDUSTRIAL CHEMICALS, INC.**

60 EAST 42nd STREET • NEW YORK, N. Y.

A Subsidiary of U. S. Industrial Alcohol Co. Branches in All Principal Cities

## Warriors of Mercy



U.S.I. Pure Alcohol is, of course, still available for hospital use on the home front. Check your requirements for alcohol with this convenient list of 21 major hospital applications... and specify U.S.I. Pure Alcohol for every use.

### CHECK LIST

#### 21 IMPORTANT HOSPITAL USES FOR ALCOHOL

- |   |   |
|---|---|
| <input type="checkbox"/> Compounding Prescriptions            | <input type="checkbox"/> Pharmaceutical Preparations          |
| <input type="checkbox"/> Cresol Compounds Dilution            | <input type="checkbox"/> Pharmacy Solvent for Vegetable Drugs |
| <input type="checkbox"/> Dehydration of Pathological Sections | <input type="checkbox"/> Preserving Specimens                 |
| <input type="checkbox"/> Drug Tincture & Extract Preparations | <input type="checkbox"/> Protein Precipitant                  |
| <input type="checkbox"/> Duodenal Drainage                    | <input type="checkbox"/> Spirit Lamps                         |
| <input type="checkbox"/> Floor Dressings and Packs            | <input type="checkbox"/> Stains and Reagents                  |
| <input type="checkbox"/> Gastric Analysis                     | <input type="checkbox"/> Sterilizing Instruments              |
| <input type="checkbox"/> Hand Rinsing After Scrub-up          | <input type="checkbox"/> Sterilizing Skin                     |
| <input type="checkbox"/> Hypodermic Injections                | <input type="checkbox"/> Surgical Soap Preparation            |
| <input type="checkbox"/> Massage and Sponge                   | <input type="checkbox"/> Sutures Sterile Solution             |
|   | <input type="checkbox"/> Therapeutic Nerve Block              |



# PURE ALCOHOL

## Essential Occupations List Is Guide Only, Not Blanket Deferment Order

WASHINGTON, D. C.—The occupational bulletins that list essential occupations in specified activities are intended to serve only as a guide to local draft boards, the Selective Service Bureau of the War Manpower Commission announced January 9. They are not orders for blanket deferment of men engaged in such occupations. A move has gained headway in Congress to remove draft administration from the Manpower Commission and place it completely

under the War Department. It is thought, however, that the administration will oppose such action on the grounds that industrial and agricultural manpower needs must be coordinated with the requirements of the military authorities.

The bulletin on health and welfare services covers offices of physicians, surgeons, dentists, oculists, osteopaths, mortuary services, podiatrists and veterinarians; medical and dental laboratories; hospitals; nursing services; institutional care; auxiliary civilian welfare services to the armed forces; welfare services to war workers and their families.

## Amending of Regulation No. 1 Eases Some Hospital Problems

WASHINGTON, D. C.—Priorities Regulation No. 1, the basic document of the priorities system, was amended December 30 to ease an occasional problem of ownership of something one no longer needs or wants. This means that hospital administrators may, under certain circumstances, sell, return or use for another purpose material they have purchased with the help of preference ratings.

The owner now may use it to fill purchase orders placed with him which bear a rating of AA-5 or higher (or a rating at least as high as that upon which the material was obtained) provided such use is permitted by other regulations and orders controlling the production or distribution of the particular material or item. He may use it for his own needs, if he has been authorized to obtain material for such use, by applying or extending a preference rating of AA-5 or higher. He may return the material to the person from whom he purchased it.

If the owner cannot use it or dispose of the material in any of these ways, he may file a report with his W.P.B. regional office which will assist him in getting rid of it. The principal effect of the amendment will be upon finished products and subassemblies, sale of which is not covered by the terms of Priorities Regulation No. 13.

## Industrial Instruments Restricted

WASHINGTON, D. C.—Industrial thermometers, pressure gauges, control valves and other industrial instruments were placed under the control of W.P.B. on December 24. An industrial type of instrument is defined in Order L-234 as any new mechanism of the following kinds: millivoltmeter "pyrometer (does not include any portable pyrometer); potentiometer pyrometer; tube system temperature instrument; differential flow and liquid level instrument; liquid level float instrument; industrial thermometer; pressure gauge; control valve; regulator.

## Small Firms Supply Medical Corps

WASHINGTON, D. C.—More than 80 per cent of all prime contracts and more than 70 per cent of all subcontracts of the medical department of the Army are being carried out by firms employing fewer than 500 persons. These contracts total in the aggregate approximately \$50,000,000. Small concerns throughout the United States are manufacturing and processing more than 80 per cent of all bandages supplied to the Medical Corps, in addition to the same proportion of surgical and dental instruments.



## A New Value Every Hospital Wants!

### The "Individual Care" Bassinet Stand

**\$29.<sup>95</sup>** Filling modern demands for individual infant equipment at a new low cost, this stand has proved a hospital hit. At a recent meeting, its first showing brought instant sales in quantity. It's priced at just about half what you'd expect to pay, allowing more infants to have this modern benefit. The frame is made of sturdy steel tubing, the entire bassinet stand welded into a solid whole. A basin ring is located in the left compartment. A sliding tray for the infant is 22½ x 13⅞ inches. Ample room is provided for storage of blankets and other supplies.

JP9293—"Individual Care" Bassinet Stand, standard size with Bassinet, on 2-inch casters.....\$29.95

SHARP & SMITH HOSPITAL DIVISION

**A. S. ALOE COMPANY**

1831 Olive Street

St. Louis, Missouri





# KIMBLE'S NEUTRAGLAS (N-51A GLASS)

The Line of MOST Resistance



For Assurance

## SERUM BOTTLES AND MOLDED GLASS CONTAINERS

KIMBLE NEUTRAGLAS—especially designed for maximum safety in packaging pharmaceuticals and biologicals—offers the highest resistance to chemical attack and solvent action.

Protect the quality, potency and pH value of your products by standardizing NOW on Kimble Ampuls, Serum Vials, Serum Bottles and Clinical Glass containers made of NEUTRAGLAS (N-51A Glass)—CLINICALLY SAFE.



• • • The Visible Guarantee of Invisible Quality • • •

**KIMBLE GLASS COMPANY . . . . VINELAND, N. J.**  
NEW YORK • CHICAGO • PHILADELPHIA • DETROIT • BOSTON • INDIANAPOLIS • SAN FRANCISCO



## Oklahoma and W.P.B. Authorities in Conflict Over Heating of Hospital

An order to cut off the gas heating equipment at Eastern State Hospital, Vinita, Okla., within an hour recently caused Gov. Leon C. Phillips to warn a representative of the W.P.B. that he would "try him for murder," if the order were carried out, it was reported in the *Tulsa Daily World* on December 15.

The gas was ordered cut off because W.P.B. had ruled that the 2800 bed hospital had stand-by oil burning equip-

ment that would serve the institution. However, W. M. Bell, chairman of the board of affairs, stated that the institution had only four boilers and one of these had no burners. An application for burners had been rejected.

In an exclusive interview, Everett W. Jones, head hospital consultant of the Governmental Division, W.P.B., told *The MODERN HOSPITAL* that the hospital's application for burners was originally denied because it had been incom-

pletely filled out. The acuteness of the situation at Eastern State Hospital had not been made clear to Washington officials. The facts of the case were explained as follows:

"On October 18 a PD-1A application was received from the Eastern Oklahoma State Hospital, Vinita, Okla., for what appeared to be simply a stand-by oil burner. This application was typical of many in that insufficient details were given to allow judgment as to its real necessity.

"Many such applications must be summarily denied because we have not enough hours in a day or enough stenographers to write back for the necessary information to the thousands of institutions that send applications lacking in essential details.

"At some later date a letter was received from the superintendent, Dr. Felix M. Adams, explaining that the hospital's contract with the gas company called for stand-by oil burners to provide steam in the event of necessary curtailment of service in certain periods. The letter also made clear that the hospital had a storage tank full of oil.

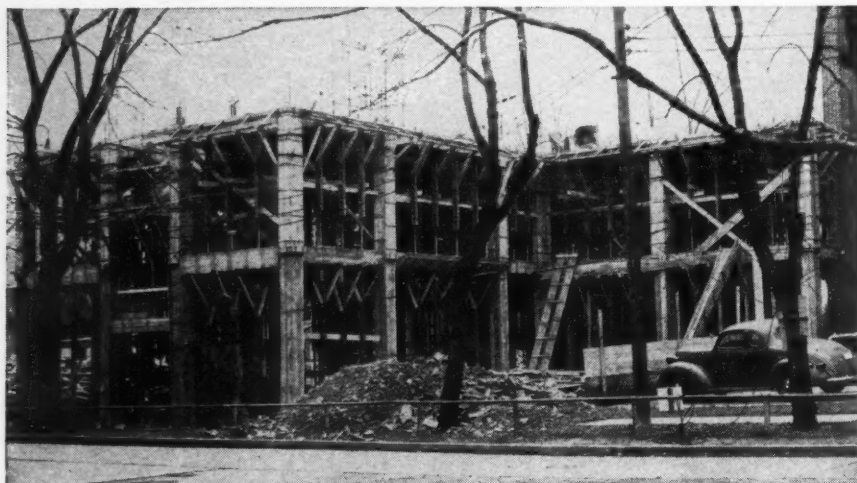
"As soon as Doctor Adams' letter was received, the application was taken out of the priority files for reconsideration, but a week or more is required to get an application reconsidered.

"The case was approved as essential by the hospital section of the Governmental Division and sent to the Plumbing and Heating Division for consideration. Some difficulty developed over jurisdiction among the Plumbing and Heating Division, the Power Division and the Office of Petroleum Coordinator. The hospital section, however, was successful in getting emergency action from the Office of the Petroleum Coordinator and in obtaining priorities to allow the burners to be released.

"If the hospital had called the nearest W.P.B. field office, when the problem first arose, to explain the entire situation, the representative would undoubtedly have promptly given instructions as to what kind of story must be told on form PD-1A," Mr. Jones asserted.

### Red Cross Recruitments Launched

The recruiting of some 30,000 graduate registered nurses for the Army and Navy Nurse Corps, 100,000 Red Cross nurses' aides and 1,000,000 students in Red Cross home nursing classes was launched January 17 with the first of a series of broadcasts from Washington over N.B.C. The thirteen week series will include a thirty minute dramatic weekly series and two fifteen minute transcribed dramatic programs each week. Howard Lindsey and Dorothy Stickney, stars of "Life With Father," opened the series.



Construction as of November 15, 1942, on a new wing of the *Christian H. Buhl Hospital, Sharon, Pennsylvania*. Fund campaign closed June, 1942, with \$302,815 raised.

## They're still building!

Among hospitals, served by Ketchum, where construction has been started or steps taken preparatory to construction:

**LATROBE HOSPITAL, Latrobe, Pennsylvania**

Ground broken November 15, 1942. Construction begun.

**MASSILLON CITY HOSPITAL, Massillon, Ohio**

Brickwork completed to roof; to be completed shortly.

**WESSON MEMORIAL HOSPITAL, Springfield, Massachusetts**

Construction scheduled to start in January, 1943.

**CHRISTIAN H. BUHL HOSPITAL, Sharon, Pennsylvania**

Construction under way; to be completed soon.

It is worth noting that the Hospital Section of the War Production Board has given the green light to a number of hospitals where new construction was necessary and funds for going ahead were available.

If your hospital needs funds for expansion or remodeling, expert direction of the financing effort may help smooth the way. Write to

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The doctor I work for is one of the busiest pediatricians in town.

When I started working for him, I noticed that he was prescribing plain cow's milk modified—almost as routine. Once in a while when he had a problem case—he would look to S-M-A as his trouble-shooter.

Well, that made me wonder. If S-M-A\* worked so well in tough cases . . . wouldn't it work even better on normal infants?

I mentioned this to the doctor. For a minute, he looked as if he was going to bawl me out. But instead, he said it sounded like a good idea. He decided to try S-M-A on all of his patients . . . for a while.

The results were so successful . . . he gave me a raise last week!

★ ★ ★

Why don't you try S-M-A in your own practice, doctor? See if it doesn't work better.



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With the exception of Vitamin C . . . S-M-A is nutritionally complete. Vitamins B<sub>1</sub>, D and A are included in adequate proportion . . . ready to feed. Their presence in S-M-A prevents the development of subclinical vitamin deficiencies . . . because the infant gets all the necessary vitamins right from the start.

S-M-A has still another highly important advantage not found in other modified milk formulas. It contains a special fat that resembles breast milk fat . . . resembles it chemically and physically—according to impartial laboratory tests. S-M-A fat is more readily digested and tolerated by most infants than cow's milk fat.

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WARM, BOILED WATER,  
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The infant food that is  
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S-M-A, a trade-mark of S.M.A. Corporation, for its brand of food especially prepared for infant feeding—derived from tuberculin-tested cow's milk, the fat of which is replaced by animal and vegetable fats, including biologically tested cod liver oil; with the addi-

tion of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrate and ash, in chemical constants of the fat and physical properties.

## Nursing Executives for Emergency Base Hospitals to Be Named by U.S.P.H.S.

By EVA ADAMS CROSS  
Washington Representative, The MODERN HOSPITAL

The surgeon general of the U. S. Public Health Service has authorized the appointment of a limited number of qualified nurses with supervisory and administrative experience to serve, if military necessity requires, as nursing executives at emergency base hospitals. It is not intended, however, at present, to establish a general nursing reserve in the U.S.P.H.S. for this purpose.

The nursing executives chosen will be offered appointments in the Public Health Service on an inactive status. When on duty they will be entitled to payment by the U.S.P.H.S. according to their experience and qualifications at per diem rates based upon annual salaries of \$2600 or \$2300 and necessary travel and maintenance when away from their usual places of residence.

### Military Neuropsychiatry School Opens

WASHINGTON, D. C.—The Army's School of Military Neuropsychiatry opened January 4 at Lawson General Hospital, Atlanta, Ga., for a four weeks' course. Only those medical officers who

have had a minimum of twelve months' full-time training or practical experience in neurology or psychiatry are eligible to attend. Each service command, the Office of the Surgeon General and the Army Air Forces have quotas.

### O.C.D. Plasma Reserves Now Ready to Care for Casualties

WASHINGTON, D. C.—Plasma reserves are now available, Dr. George Baehr declared in a recent circular, in every civilian defense region for use in the event of casualties resulting from enemy action or sabotage. The regional medical officer will keep all chiefs of Emergency Medical Service, hospitals and Red Cross disaster relief chairmen informed concerning the amount and distribution of plasma reserves available in the state and the method of obtaining additional supplies in emergencies.

In cities in which reserves are stored they can be obtained by hospitals through the local chief of Emergency Medical Services. If a community is without plasma or if its supplies are depleted, the local E.M.S. chief can obtain additional plasma in emergencies from the state chief.

If O.C.D. plasma is used in nonwar related accidents, its use may be considered a loan.

## Equitable Distribution of Physicians to Assure Civilian Care Sought

WASHINGTON, D. C.—Various methods are being employed to distribute medical attention evenly for civilians to assure at least a minimum standard of medical care. Some physicians have been asked to volunteer for practice in areas other than those in which they are located. It is hoped that in most cases a physician may be relocated in the state in which he now has his license.

Dr. Frank H. Lahey, chairman of the directing board, Procurement and Assignment Service, has suggested that some method of temporary licensing be established for the duration to obtain greater mobility of physicians.

In a report released on January 10 by Doctor Lahey the following states show shortages of doctors: Alabama, Arizona, Arkansas, Colorado, Georgia, Idaho, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, South Carolina, South Dakota, Tennessee and West Virginia. Some 40 or 50 "critical areas" are under study by the Procurement and Assignment Service which is doing everything possible to place doctors where they are most needed. More than 400 physicians have already been relocated.

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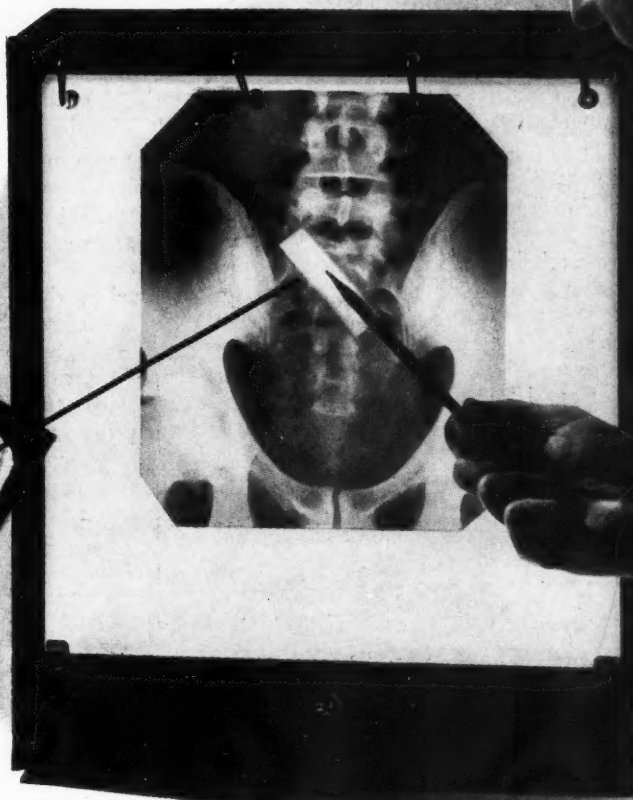
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Additional Curity Radiopaque dressings are now available for the first time. Four sizes of walling-off dressings or tape sponges (Radiopaque A. B. D. Packs) and No. 450 8" x 4" Radiopaque Sponges (Nos. 440 and 420 previously announced) provide for nearly all basic operating room needs.

The unique Curity Radiopaque Dressings enable a positive answer to the questioned sponge count, and to the post-operative complication that might be caused by a "lost" gauze dressing. The roentgen-opaque "tell-tale" is insolubly impregnated with barium sulphate, U.S.P., and is made an integral part of the dressing. Curity Radiopaque Dressings are your operating room's "insurance policy" against lost dressings or the fear of lost dressings.

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## Nursing Quota Set at 65,000 for 1943; 10,000 Above 1942

WASHINGTON, D. C.—Sixty-five thousand young women must enter schools of nursing between June 30, 1943, and July 1, 1944, to meet bedrock needs of civilians and the armed forces. This conclusion was reached by the subcommittees on nursing and hospitals at a meeting in Washington in January. The quota exceeds that of 1942-43 by 10,000. Directors of hospitals and heads of nursing schools are urged to shorten the period of training from three years to thirty months, or less in some instances.

The suggested adjustments in school curriculums recommended by the Health and Medical Committee, O.D.H.W.S., are designed to supplement recommendations contained in the bulletin, "Nursing Education in War Time," put out by the National League of Nursing Education. Federal and private scholarships for nursing education are available. Details regarding all phases of student entrance requirements can be obtained from the National Committee on the Recruitment of Student Nurses, 1790 Broadway, New York City. Basic qualifications demanded of an entrant are: she must be between 18 and 35 years of age, be physically fit and have at least a high school education.

## Hospitals Must Train Own Auxiliary Workers, O.D.H.W.S. Decrees

WASHINGTON, D. C.—Responsibility for employing and training auxiliary hospital workers rests with the individual hospital, according to an agreement reached in Washington early in January by the subcommittees on hospitals and nursing of the Health and Medical Committee, O.D.H.W.S.

It is neither desirable nor practicable for the federal government to foster a training program for hospital auxiliary workers, reported Dr. James A. Crabtree, executive secretary of the Health and Medical Committee. The problem is entirely local, he concluded.

The Training Within Industry program is available to hospitals on a limited basis, it was stated recently by C. R. Dooley, director of the program.

Any hospital that wants job instructor training should get in touch with the district headquarters, Mr. Dooley explained, and arrange either to have the district assign a trainer to present the program to a hospital group, or to send a competent person to a district job instructor training institute to receive the training that will qualify him to return to the hospital and train staff members or employees there.

## Specialty Courses for Doctors Will Alleviate Army Shortage

The War Department has announced a series of special intensive courses whereby several thousand additional medical and dental officers will become sufficiently qualified to alleviate the shortage of doctors and dentists.

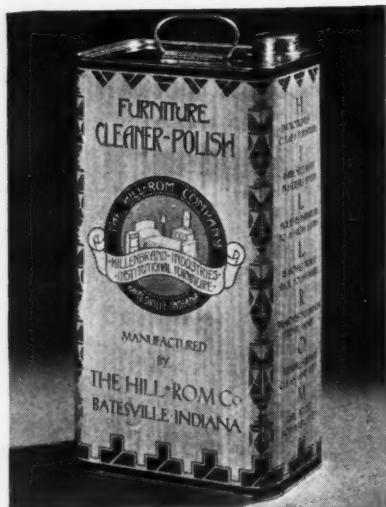
Special emphasis is to be placed on tropical medicine. The courses, lasting six weeks in some instances, twelve in others, will be provided at both civilian educational institutions and military installations. From 200 to 400 officers will be selected for each of the courses.

Attorney General Francis Biddle announced January 16 that the Immigration and Naturalization Service has been directed to expedite the naturalization of alien physicians.

## Storage Battery Production Up

WASHINGTON, D. C.—To provide an adequate supply of electric storage batteries for replacement in vehicles, the production quota for 1943 is established at 100 per cent of the number sold during 1941 under the terms of Limitation Order L-180, as amended January 5. The production for the second half of 1942 was only 90 per cent of the number of replacement batteries sold during the corresponding period in 1941.

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## GENERAL NEWS

### James R. Clark Named by A.H.A. to Direct War Service Bureau

James R. Clark, superintendent, Southside Hospital, Bay Shore, Long Island, N. Y., has been appointed to head the War-Time Service Bureau of the A.H.A. which was authorized at the St. Louis convention.

Mr. Clark has been in hospital administrative work since 1928. He was born in Philadelphia and is 36 years old. His education was obtained at Temple University and he attended the Chicago Institute for Hospital Administrators in 1934.

From 1926 to 1928, Mr. Clark was an efficiency engineer in New York. He then became associated with Jewish Hospital of Brooklyn, first as executive secretary and then as assistant director. He became director of the Southside Hospital in 1935.

Mr. Clark is a member of the A.C.H.A., the A.H.A., the New York State Hospital Association and the Greater New York Hospital Association.

He is a member of the public and medical subcommittee to study hospital standardization of the latter group. He has been secretary-treasurer, membership committee member and vice president of the Hospital Council of Brooklyn.

Mr. Clark takes office on February 1. Although the details are not yet settled, he will probably have something of a staff to assist him in Washington.

### Texas and New England Associations to Convene; Mid-West Group Cancels

Announcements regarding conventions for 1943 made by three hospital associations reveal that the Mid-West Hospital Association has decided to cancel its annual meeting, while those of the Texas and New England groups will be held in accordance with earlier plans.

At a breakfast meeting of the trustees and members of the Mid-West Hospital Association during the A.H.A. convention in October, it was decided to have the present officers continue in office and to make no change in the combined office of executive secretary and treasurer for the present. The name of John F. Latham will continue to be carried

and the work of the secretary-treasurer will be handled in the office of the association president.

The war conference of the Texas Hospital Association at the Hotel Texas in Fort Worth, February 18 and 19, is planned solely for the purpose of furnishing to hospital administrators information vital to the effective functioning of hospitals in war time. Exhibits have been eliminated. James A. Hamilton, A.H.A. president, will be the principal speaker.

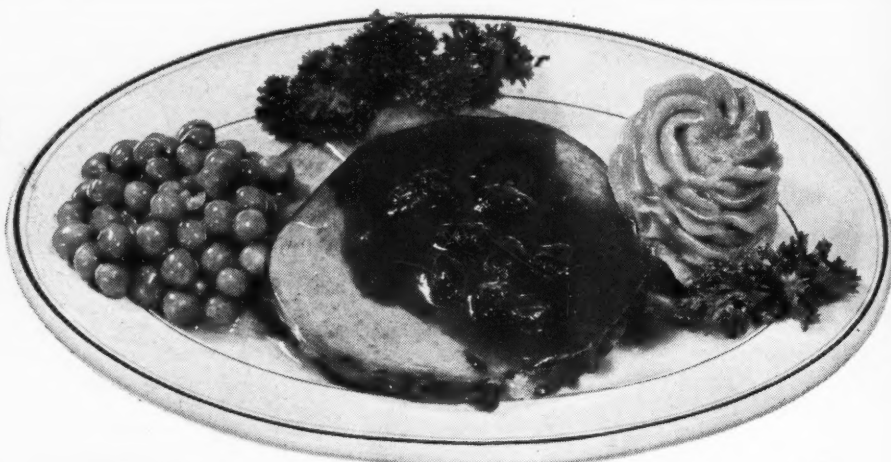
In view of the recent disaster in Boston, exhibits at the New England Hospital Assembly, March 10 to 12, will be confined to those that are completely fireproof. Dr. Wilmar M. Allen, president of the New England group, has announced that governmental and other nationally known speakers will participate in the three day session.

### \$4,000,000 for Clinic

An endowment of nearly \$4,000,000 for the creation of a combined clinic hospital and free research center for the treatment of tuberculous patients at Pasadena, Calif., has been authorized in the will of Charles H. Hastings. The hospital will be known as the Charles Cook Hastings Home in memory of the donor's father, who died of tuberculosis.

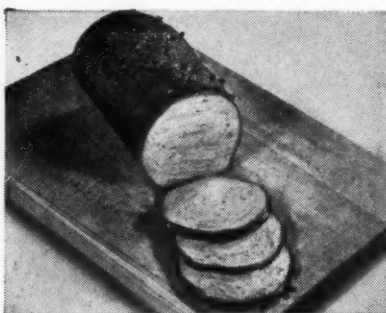
## New Appetite Appeal for Your Trays

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● In this new, delicious low-cost entrée, Armour's internationally famous chef, Jean Lesparre, has taken an inexpensive sausage...given it the taste appeal of many more elaborate entrées! Just the nourishing dish you need to meet your rising meal-cost problems! The delicious trick to this meal is a tasty new glaze in which to bake the bologna! To get the recipe for Star Bologna Glacé—and other new recipes each month...just fill in the coupon to the right.

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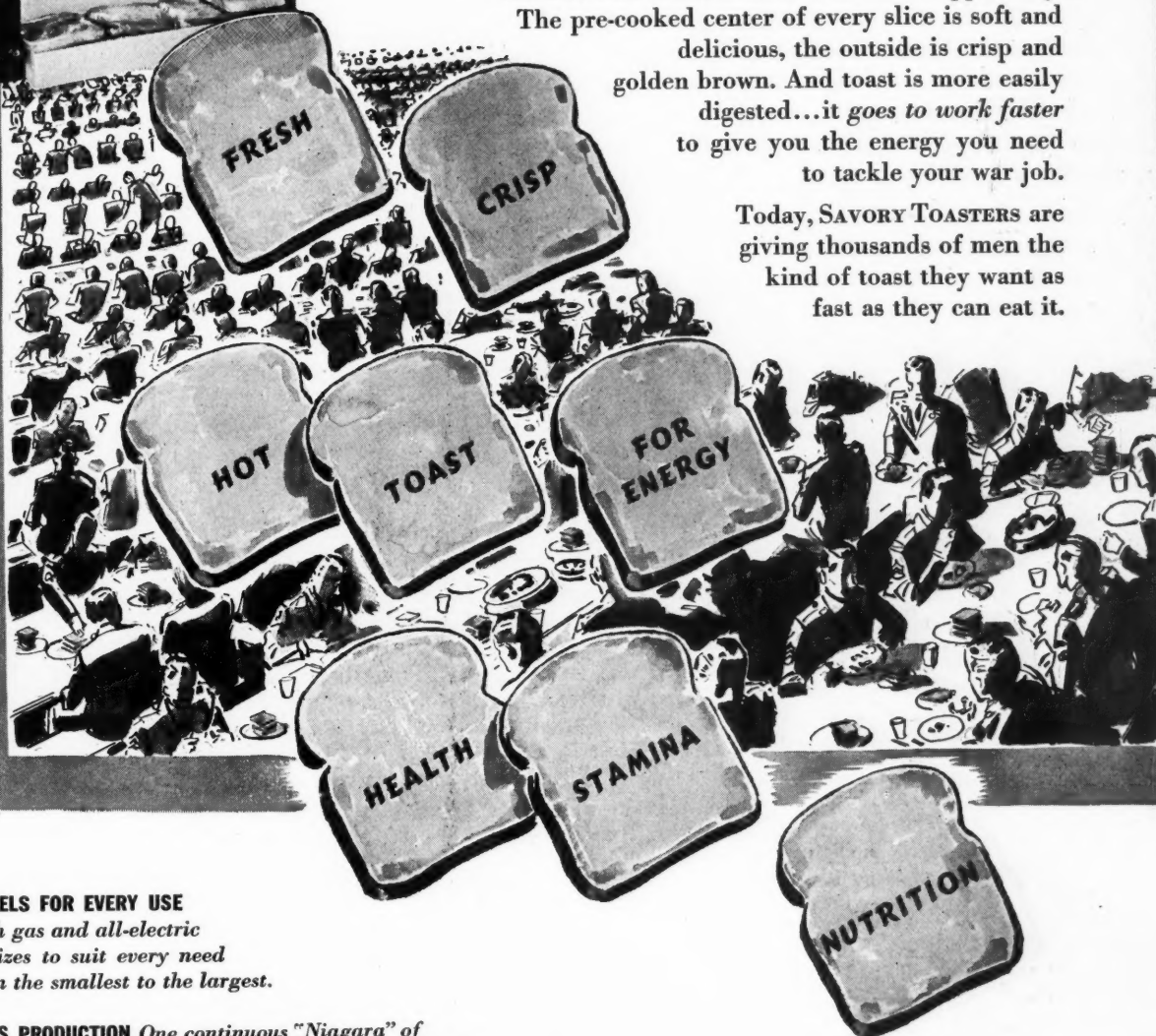
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## *Ammunition for our fighting men!*

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**SAVES DAILY BAKING** *Savory makes fresh, soft-centered golden-brown toast, even from three-day-old bread.*

**EFFICIENT** *Saves time, labor, fuel and money.*

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## W.L.B. Orders \$20 per Month Wage Increase in 11 San Francisco Hospitals

The National War Labor Board on January 2 issued a directive to the 11 leading nongovernmental hospitals of San Francisco ordering them to grant pay increases of \$20 per month to their 875 maintenance employees. The pay increase, in accordance with an agreement between the hospitals and the Hospital and Institutional Workers' Union, is to be retroactive to Aug. 1, 1942, and can be paid in eight equal installments ending on April 18. Thus, the hospitals must pay \$87,500 in back pay and must readjust their pay schedules for these employees and also for higher paid employees in order to preserve existing differentials.

The background of this hospital wage dispute was outlined in *The MODERN HOSPITAL* for October (page 126).

The decision of the National War Labor Board, which upheld the majority decision of the local panel, was unanimous with two members each from the public, employers and employees participating in the review. This decision is of great significance to hospitals since it is the first such case to be carried to the W.L.B. under Executive Orders 9017 and 9250.

In the report and recommendations of the local panel, the majority condemns hospital salaries in vigorous terms. "It is a matter of common knowledge," states the majority report signed by Paul A. Dodd, representing the public, and John A. Shelby, representing labor, "that hospital employees' wages have for many years been notoriously and unreasonably low, and comparison with a large number of such low rates only indicates the need for a review of such rates on a national basis. Thus, the suggestion of the Hospital Conference that no wage increase is justifiable because of the results of the above survey (of hospital wage rates by *The MODERN HOSPITAL*) could only be accepted if this panel were to take the highly unrealistic position that the surveyed hospitals pay a decent and living wage."

The panel decided, and the W.L.B. agreed, that the wages should be increased on the basis of (1) increases in the cost of living since Jan. 1, 1941, (2) elimination of substandard levels of hospital wages, (3) elimination of inequalities between the wages paid by the voluntary hospitals and those paid

by the governmental and proprietary hospitals of the area, as well as those paid for similar work in other types of employment, and (4) the hospitals' ability to pay.

On point 1, the panel found that hospital wages had increased less than 3 per cent since Jan. 1, 1941, and should, therefore, be increased by slightly more than 12 per cent to meet the "Little Steel" formula. On point 2, the panel stated that wages of \$92.50 for men and \$87.50 for women were obviously substandard. "To attempt to support a family, or even a single person, at a minimum state of health and decency on these wages would appear to be economically impossible."

The majority of the panel was not impressed by the hospital evidence of inability to pay higher wages. It was suggested that low-cost group hospitalization insurance programs be developed as a long-range means for increasing hospital income. As an immediate palliative, the raising of hospital rates was suggested; it was computed that an increase of 25 cents per patient day would be sufficient to meet the cost of each \$10 per month increase granted. Hence, an increase of 50 cents would meet the present requirements.

The employer representative on the panel, Dr. Howard H. Johnson, super-

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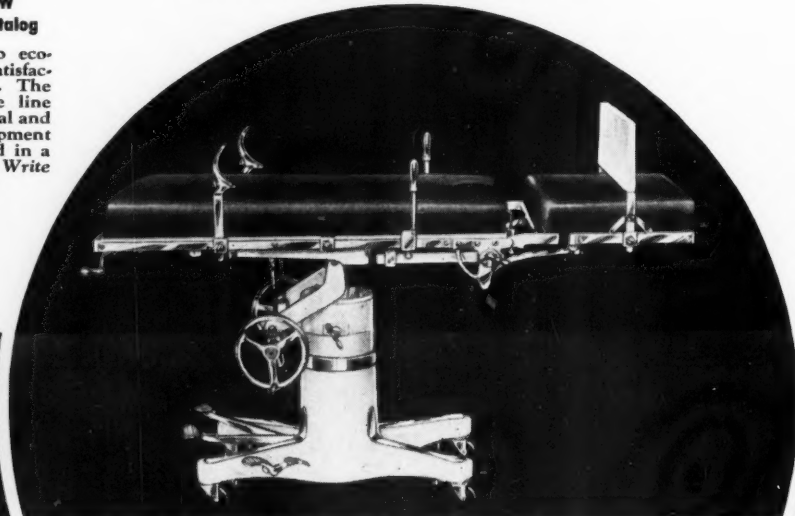
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Stable, Portable 'Lyovac' Normal Human Plasma is particularly well adapted to use under adverse and mobile conditions and can be kept safely without refrigeration wherever treatment of shock may be

required . . . in accident room or ambulance, operating room, delivery room, or offices, in first-aid stations and mobile disaster units.

Stability is assured by means of quick freezing, followed by desiccation and storage under vacuum in a stoppered, flame-sealed glass vial. Restoration is simple and rapid. Each 250-cc. unit of 'Lyovac' Normal Human Plasma provides approximately as much osmotically active protein as 500 cc. of whole blood, and hypertonic (concentrated) solutions can be easily prepared when required.

A 16% reduction of the list price of 'Lyovac' Normal Human Plasma has recently been made as a result of improvements developed by Sharp & Dohme. 'Lyovac' Normal Human Plasma has been accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

**'LYOVAC' NORMAL HUMAN PLASMA**

*Sharp & Dohme*  
PHILADELPHIA

1. Annals of Surgery, 115:1125, June, 1942

intendent of St. Luke's Hospital, based his strong opposition primarily on two points: (1) the decision is sharply inflationary and will tend to break down the President's efforts to control the inflationary spiral and (2) the hospitals are unable to pay any increased wages, much less the amount ordered, and the public is unable to meet higher charges. He stated that the wages paid in San Francisco are the highest paid to hospital institutional workers in any area in the United States.

In the case of his own hospital, Doctor Johnson asserted that the increase will add 97 cents per day to the per capita cost, bringing it to a total of \$12.13. This increase, he said, will develop a new group of underprivileged or semi-indigent patients, namely, those living on fixed incomes. He proposed a 6¼ per cent increase as "the most generous and most fair that is warranted under the circumstances."

#### Pennsylvania Group Shortens Meeting

Owing to the exigencies of war, the Hospital Association of Pennsylvania has shortened its 1943 war conference from three days to two, it has been announced. The dates are now Thursday and Friday, April 15 and 16, with headquarters at the Bellevue-Stratford Hotel, Philadelphia.

#### New York City Hospitals Suffer From Fuel Shortage

The fuel oil situation in some of the New York City hospitals is becoming increasingly acute, it has been reported. At Lenox Hill Hospital, John Hayes, administrator, revealed that at one time the institution had enough fuel for only four or five hours, and New York Hospital was reduced to only one hour's supply.

Hospitals that have coal burning equipment have been in little better case. On one occasion Columbia-Presbyterian Hospital had to send a barge out to obtain enough coal to keep the heating equipment operating.

Among the measures that are being studied by hospital administrators to alleviate the situation is the possibility of purchasing steam from the city, a practice followed by many large office buildings. However, it was stated, such an installation would take at least eight weeks.

The price of fuel oil in New York City has risen by about 70 per cent from 1939 to 1942 and further increases were announced in January, according to H. P. Schwarzman of the Joint Purchasing Corporation. He indicates that the government may be permitting price increases in oil to force consumers to convert to coal. But the effect of this

price rise, he suggests, may be offset in part by increases in coal prices and by a government order limiting stocks in the hands of hospitals and other consumers to a ten day supply.

#### Nurse Enlistment Pamphlets Out; Recruiting Film Ready

A revision of the pamphlet advising nurses whether to enlist or to stay in civilian nursing was issued in January by the National Nursing Council for War Service, Inc., under the title "Priorities for Nurses." A new supplementary leaflet goes into details regarding factors affecting general staff, institutional, office, private duty and public health nurses. A new recruitment folder entitled "War Work With a Future—Nursing" has also been issued by the council. A copy of any of these folders will be provided on request to the council at 1790 Broadway, New York City.

The nursing recruitment film of the American College of Surgeons, "R.N.—Serving All Mankind" had its premiere in Chicago on January 8. One hundred fifty copies are available in both 16 and 35 mm. sizes for free use by any interested groups. A small fee for postage and service only is required. This film was described in *The Modern Hospital* for October.



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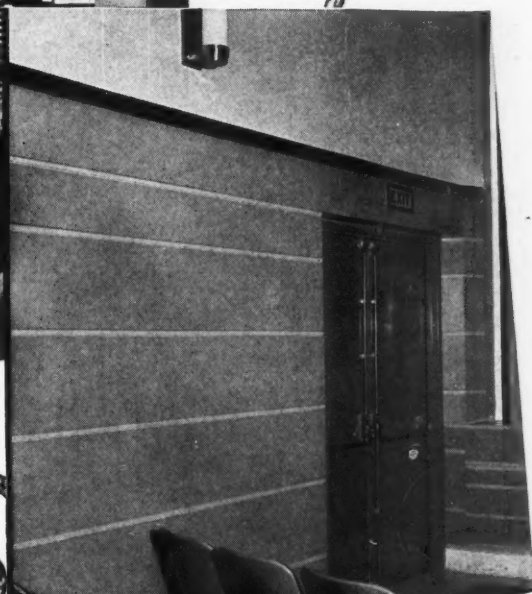
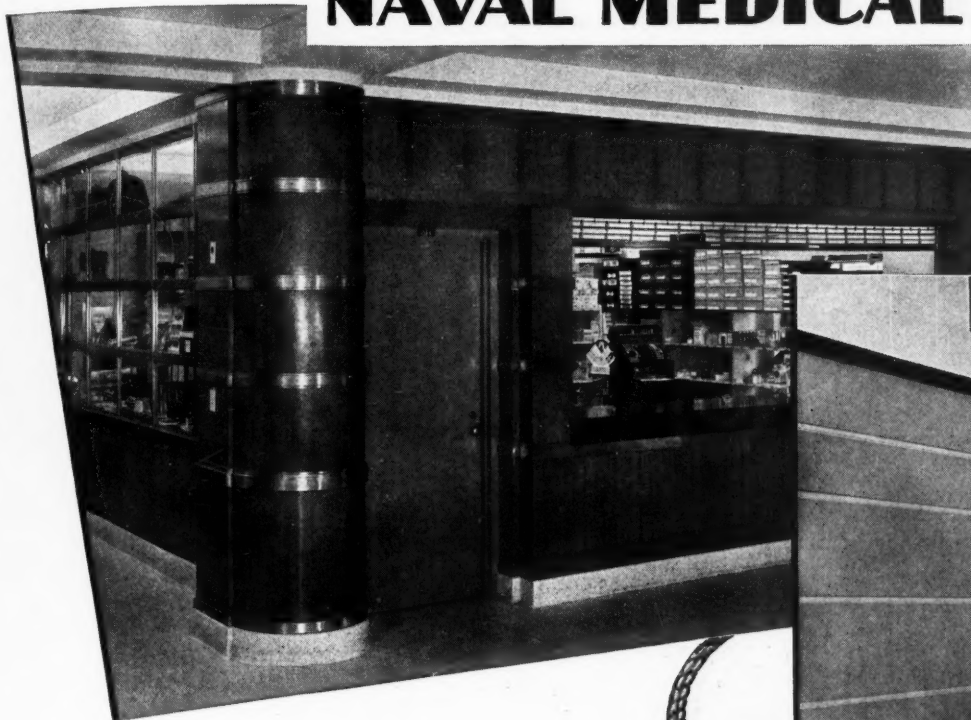
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Lacewood Realwood—a plastic sheet incorporating a real Lacewood veneer—was used on the walls and doors of the hospital shop where the counter top was also Formica.

In the handsome elevator cabs provided by the W. S. Tyler Company the top panels were Prima Vera Realwood with aluminum inlays.

And there is an auditorium with Formica walls in an orchid color, installed by John C. Knipp, Baltimore.

Other hospital uses for Formica include: Shelving in the pharmacy, table tops in dining rooms, tops for dressers, bedside table and overbed tables. Manufacturers of hospital furniture provide Formica tops on specification.

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## Difficulties of Paris Hospitals Are Revealed; Germans Take Over Three

Three Paris hospitals, Beaujon, Lariboisiere and La Pitie, comprising 3280 beds, have been requisitioned by the German authorities, according to a recent release, "Public Health Under Hitler's Rule," from the British press service. Owing to the creation of temporary hospitals, the release states, Paris patients still dispose of 36,800 hospital beds, a small proportion of the city's estimated population of 4,200,000.

Few Parisians go to hospitals these days except in the last extremity because food cards must be deposited upon entering the hospital and interminable formalities are required to get them back on leaving. British patients remaining in Paris are cared for at Val-de-Grace Hospital and Jewish patients, at the Rothschild Foundation.

Among the other difficulties suffered by Paris hospitals is the lack of ambulances. Patients are brought in with the help of the police first aid and for the return journey they are grouped in the same ambulance, which makes a round trip like a motor bus.

Although no general mortality rates have been released, it has been revealed that the annual rate of deaths at Cochin

Hospital has increased from 1200 to 1400. Tuberculosis is said to have doubled among 6 to 8 year old children and in the 18 to 25 year age group.

## Adhesive Plaster, Dental Needles Practices Simplified

Two simplified practice recommendations that have recently been announced by the Bureau of Standards, U. S. Department of Commerce, affect adhesive plaster and dental hypodermic needles.

Effective January 1, six lengths of all types of 25 gage dental hypodermic needles, one 26 gage length and all of the 23 gage needles listed in the recommendation will be eliminated. This represents a reduction of from three gages to one and from 22 lengths to eight for all types of these needles.

Revisions in the recommendations for adhesive plaster, to become effective on February 1, eliminate the following: 12 inch in 10 yard uncut rolls of plain and waterproof adhesive; 12 inch waterproof rolls cut  $\frac{1}{4}$  and  $1\frac{1}{2}$  inch;  $1\frac{1}{2}$  inch spool adhesive in 5 yard lengths, plain and waterproof; 2 inch in 10 yard lengths and 3 inch in 10 and 5 yard lengths, waterproof; 3 inch in 10 yard lengths, plain, and  $\frac{1}{2}$  inch in  $2\frac{1}{2}$  yard lengths, plain and waterproof.

## Blue Cross Plans Enroll 10,459,000; Goal 15,000,000

A total enrollment on January 1 of 10,459,000 was recorded for the 77 approved Blue Cross plans, a somewhat disappointing figure in view of predictions of 11,000,000 enrollment. The quota of 15,000,000 for 1943, therefore, will require increases of 4,500,000 instead of 4,000,000 as expected.

The net growth for the year 1942 was 2,003,000. Plans showing a net growth of more than 25,000 subscribers and dependents during the year were: Chicago, 115,000; Massachusetts, 111,000; Cincinnati, 100,000; Philadelphia, 95,000; Toronto, 92,000; Cleveland, 90,000; Buffalo, 82,000; Pittsburgh, 79,000; New Jersey, 79,000; Colorado, 75,000; Minnesota, 70,000; St. Louis, 58,000; Baltimore, 43,000; Columbus, Ohio, 37,000; Providence, R. I., 35,000; Toledo, Ohio, 35,000; Rockford, Ill., 33,000; New Haven, Conn., 33,000; Michigan, 32,000; Wisconsin, 32,000; Oregon, 31,000; Winnipeg, 31,000; New Orleans, 29,000; Kansas City, Mo., 29,000; Des Moines, Iowa, 28,000, and Rochester, N. Y., 25,000.

The 10 largest plans are in New York City, Michigan, Cleveland, Pittsburgh, Minnesota, Massachusetts, Chicago, Philadelphia, New Jersey and Cincinnati, in that order.

## More "Lab" Work to be Done— with Fewer Available Assistants...

—That's a Combination Demanding the  
MOST EFFICIENT LABORATORY EQUIPMENT

• Increased Hospitalization is the logical answer to the greater demands made upon physicians serving the civilian population.

• And improved and additional Laboratory Equipment is the logical answer to the increasing amount of Technical Work required of your Laboratories.

• Kewaunee Steel Fabricating Plants are, of course, now producing exclusively for America's War Needs.

• Kewaunee Wood Plants are however producing all models of Kewaunee Equipment at especially economical prices, due to our "Cut-Cost System" of Matched Unit Production. Time is also saved in deliveries and installations.

Write for the Kewaunee Catalog.



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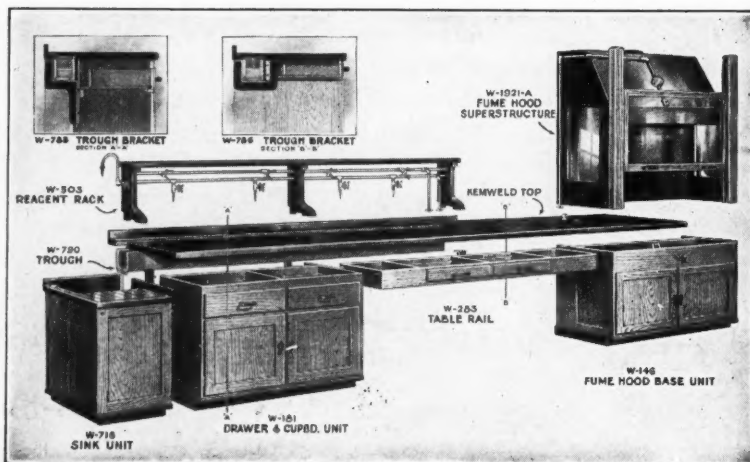


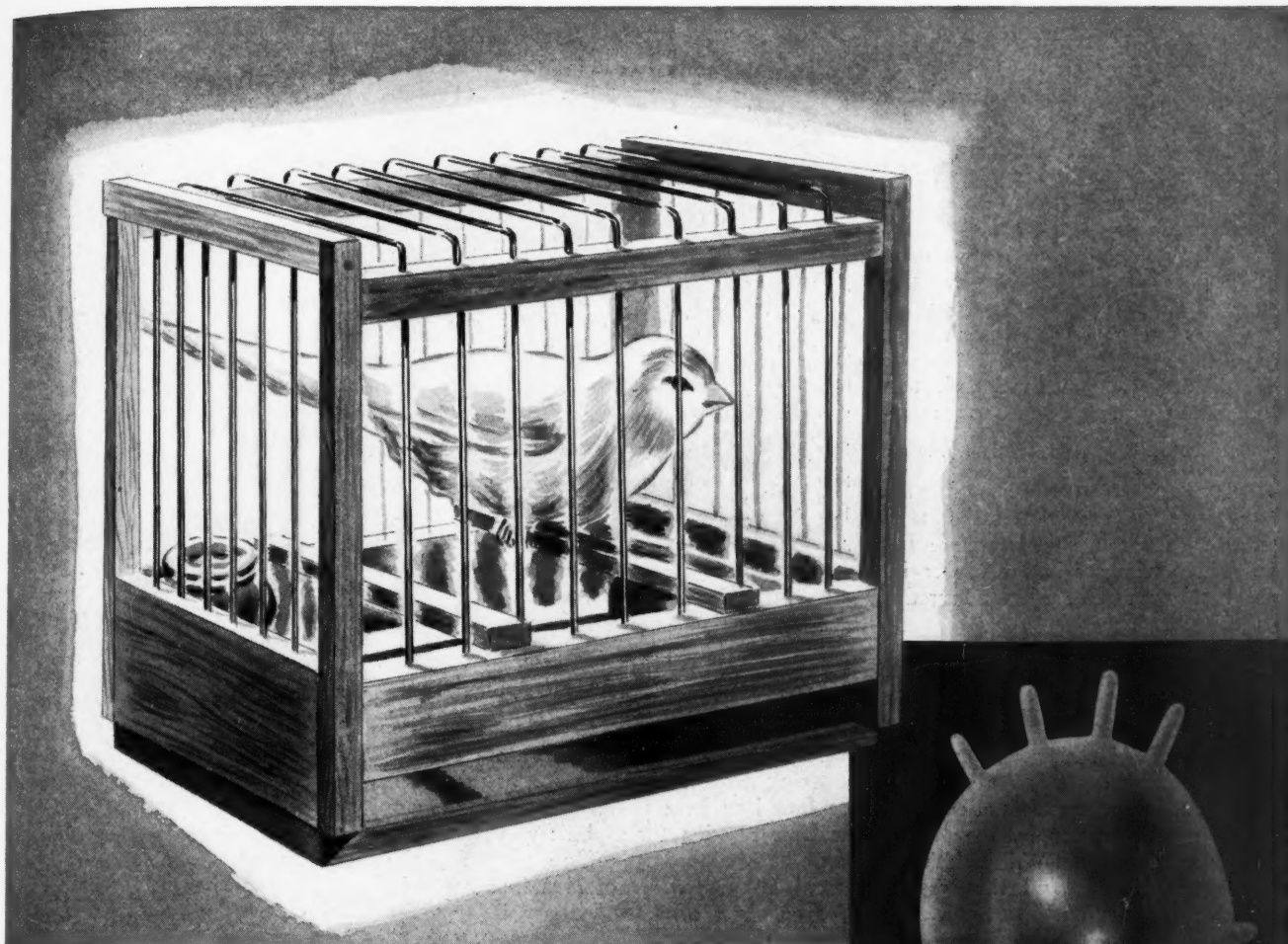
Illustration above shows how Standard Furniture Units are assembled by the Kewaunee "Cut-Cost System." This Kewaunee Laboratory Table No. W-2045 is made up of 10 Standard Kewaunee Units.

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# PLAYING SAFE

To guard against the danger of White Damp, a deadly, odorless, tasteless and invisible gas which often permeates the lower levels of coal mines, miners carry with them a canary in a small cage. A very simple yet most effective safeguard—for they know that the canary, reacting quickly to the effects of the gas, will give them ample warning of its presence. At the Wilson Rubber Company Plants another very simple yet effective method of detecting hidden dangers is found in the balloon test for Surgical Gloves pictured above. By the very simple process of inflating each glove to many times its normal size practically all danger of a glove containing weak spots or pin holes ever reaching you is done away with. Like the canary in a cage—the Wilson balloon test (only one of many tests given each Wiltex and Wilco Glove) is not very spectacular—it has no complicated instruments to back it up yet it is still the most effective way of "PLAYING SAFE" to be developed so far.

*The* **Wilson**

RUBBER COMPANY

THE WORLD'S LARGEST MANUFACTURERS OF RUBBER GLOVES

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## Another Group Health Plan Launched in New York City

Another group health insurance plan for the New York City area was announced on January 11 by Group Health Cooperative, Inc., a nonprofit medical service corporation.

At rates of \$9.60, \$19.20 and \$24 for individuals, couples and families, respectively, the plan offers surgical care in the doctor's office, hospital or the subscriber's home; obstetric care at home or at any hospital, and medical service while the subscriber is a bed patient in any hospital for any illness not requiring surgical or obstetric care.

Income limits of \$1800 for individuals, \$2500 for couples and \$3000 for families are set and doctors cannot send bills to persons with incomes below these figures. Those who are in the higher income brackets receive specified credits on their bills.

Higher subscription rates are provided for persons not on the group enrollment basis. It is reported that 2500 physicians have offered their services under the plan, which has been endorsed by local medical societies. Winslow Carlton is executive director. Initial expenses have been underwritten by the Rockefeller Foundation, Good Will and Twentieth Century Funds and the Nathan Hofheimer Foundation.

## Coming Meetings

Feb. 10—North Dakota Hospital Association, Bismarck.  
Feb. 18-19—Texas Hospital Association, Texas Hotel, Fort Worth.  
Feb. 24-25—Association of California Hospitals, San Francisco.  
March 7-11—American Association of Psychiatric Social Workers, Hotel Pennsylvania, New York.  
March 10-12—New England Hospital Assembly, Hotel Statler, Boston.  
March 20—Oklahoma State Hospital Association, Oklahoma City.  
April 15-16—Hospital Association of Pennsylvania, Bellevue-Stratford Hotel, Philadelphia.  
April 27-29—Ohio Hospital Association, Neil House, Columbus.  
April 29-May 1—Southeastern Hospital Conference, Ansley Hotel, Atlanta, Ga.  
May 5-7—Tri-State Hospital Association, Palmer House, Chicago.  
May 6-8—Carolinas-Virginias Hospital Conference, Roanoke, Va.  
May 10—Mississippi State Hospital Association, Heidelberg Hotel, Jackson.  
May 16-18—Minnesota Hospital Association, Nicollet Hotel, Minneapolis.  
May 26-28—Hospital Association of New York State, Hotel Pennsylvania, New York City.  
June 15-17—National League of Nursing Education, Chicago.

Of the 800 hospitals queried regarding their methods of handling donors who show indication of having syphilis, 603 replied. Of these, 6.5 per cent reported that they did not test blood donors for syphilis before the blood was used, and 12.5 per cent of the hospitals that did test donors had no method of notifying these donors when they were found to have a positive or doubtful reaction.

It was pointed out by the authors of the report that in order for hospitals to have a successful system for notification of donors, the problem must be handled by one person. This person, it was asserted, should be a permanent member of the hospital staff and all serologic tests for syphilis on blood donors should be reported to him.

## A.M.A. Delegates to Meet in June

Taking the place of the usual annual meeting of the American Medical Association, originally scheduled to convene in San Francisco, the association's house of delegates will foregather in Chicago on June 7. Significant problems confronting the medical profession, particularly those concerning the provision and distribution of physicians and the provision of medical services for civilian and military needs, will occupy the delegates.

## Better Method of Handling Blood Donors Urged by J.A.M.A.

That there is urgent need in many hospitals for a more definite system of notifying prospective blood donors who are found to have positive or doubtful serologic reaction for syphilis was indicated by the findings of a survey reported in the *Journal of the American Medical Association* for January 16.

# D.S.S.

## Deknatel Surgical Silk

"The Original  
Moisture and  
Serum Proof  
Silk Suture"



Comes in 12 sizes, suited to the various operations... is easily threaded... ends do not unravel. Samples from each batch are bacteriologically tested—18 days' minimum.

This braided and especially treated silk with—its extra tensile strength—its superiority where wet dressings are used—its easy and certain manipulation—its non-slipping and non-capillary qualities—is standard procedure with innumerable surgeons and many hospitals.



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**DEKNATEL  
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# D.N.O.B.

## Deknatel Name-On Beads The Original Name Beads Identification

A method of marking the new born in a safe and attractive manner... that appeals to the mother and creates lasting goodwill for the hospital.

A Necklace or Bracelet is formed by placing white letter beads to spell mother's surname onto a blue bead strand, which is tied and then sealed-on the baby at birth.

Introduced by Deknatel 20 years ago, the adoption of this method in 1940 by many more hospitals is indicative that it is still the modern, desirable baby identification.



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# Extra Shoulders



for Hospital  
Superintendents



**T**ODAY the weight of the world seemingly rests on the shoulders of every hospital superintendent. Day by day the load you carry *increases* instead of growing lighter.

The once interesting problem of securing needed supplies and equipment has suddenly become an intricate and confusing enigma that might well exhaust your energy if you should permit it to encroach too far on your time for thinking and planning.

At a time like this, the Will Ross organization is more than ever justifying the many

years of product and supplies research, broad contacts, and experience we have devoted to this one job of meeting the needs of hospitals.



We offer you our shoulders . . . to help carry the burden of your vital "service of supplies." If you need anything that can be HAD . . . Will Ross will get it for you.

## WILL ROSS, Inc.

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*Quality Hospital Supplies*

### Awarded Army-Navy "E"

Several firms in the health supplies field that have received the Army-Navy "E" award have been reported since December 15. They include: Crane Company, Chicago; Corning Glass Works, Corning, N. Y.; Formica Insulation Company, Cincinnati; Merck and Company, Incorporated, Rahway, N. J.; Sharp and Dohme, Incorporated, Biological Laboratory, Glenolden, Pa., and the pharmaceutical plant of this organization at Philadelphia; Davis & Geck, Inc., Brooklyn, N. Y.; Ciba Pharmaceutical Products, Incorporated, Summit, N. J.; Eli Lilly and Company, Indianapolis, Wallace and Tiernan Products, Inc., Belleville, N. J., and Warren Webster and Company, Camden, N. J.

### Kellogg Names Two Fellows

Fellowships in hospital administration have been granted by the W. K. Kellogg Foundation, Battle Creek, Mich., to James L. Dack and David R. Kenerson. Mr. Dack, a graduate of the University of Iowa, served his internship in hospital administration at Butterworth Hospital, Grand Rapids, Mich. Mr. Kenerson, who recently completed his administrative internship at the University of Iowa Hospitals, was business manager of New Hampshire State Hospital.

### Institute Warns Against Inferior Fire Equipment

Since the outbreak of the war much unapproved fire-fighting equipment has appeared on the market, the Safety Research Institute of New York warned recently. Announcements of these products in trade papers are interpreted by many readers as implied endorsements. The institute states that many of these devices have little protective value and that all of them are inferior, in one way or another, to approved equipment.

Any fire-fighting device can be judged by whether or not it has been approved by Underwriters' Laboratories, Inc., or by Factory Mutual Laboratories, the institute attests. Certificates of approval from these organizations may be applied for by any manufacturer of fire protection equipment.

If a manufacturer fails to apply or if approval is denied, the efficacy of his product should be questioned.

### Changes in Pittsburgh Plan Undecided

No official action has yet been taken by the Hospital Service Association of Pittsburgh on the changes in its contract which are under discussion now with member hospitals and which were reported in last month's issue of *The Modern Hospital*, according to an

announcement from Abraham Oseroff, vice president. "We have been consulting with our member hospitals in groups and individually for the purpose of clarifying sections of our present subscriber's contract and to make certain that benefits provided in any new contract may be offered on a sound basis," Mr. Oseroff states.

### Purchase of Additional Space Okayed for Hillcrest Hospital

A grant of \$228,000 has been made by the Federal Works Agency to Hillcrest Memorial Hospital, Tulsa, Okla., for the purchase of an apartment hotel to be converted to use by the hospital. Necessitated by the increasing demands placed upon the hospital's facilities, the hotel will be remodeled to add 153 beds to the hospital's capacity, bringing it to 358. Extensive improvements in the existing hospital are to be made also.

The F.W.A. grant will include the following: purchase of the Morningside apartment hotel; remodeling and renovating the building and adding an elevator; new equipment in both buildings, to include surgical supplies; new delivery rooms and equipment; new operating rooms and equipment; new furniture; flake ice machines, and a laundry for the new building.

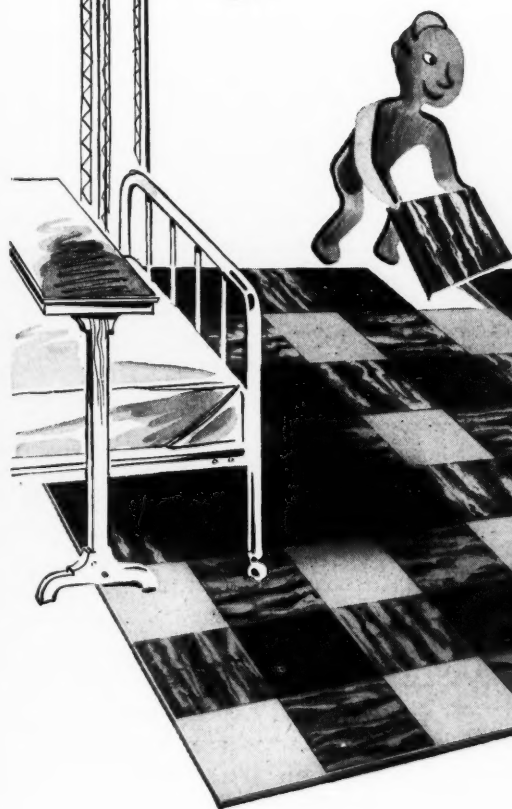
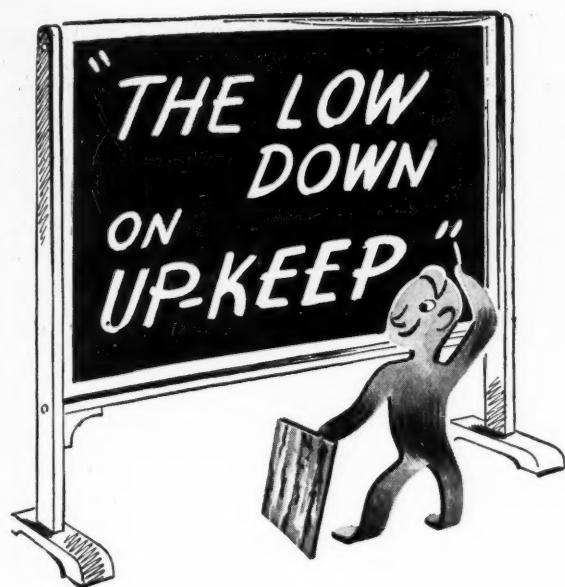
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1. Stain resistance (Kentile is impervious to every kind of common staining substance).
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4. Durability (Kentile is so rugged it is even used in heavy duty plants; 15 years of service have proved it in such places as the busy corridors of Rockefeller Center, the government's largest buildings, etc. An interesting testimony to Kentile's quality is its selection by the Bell Telephone Laboratories after they had tested almost every floor made for 6 months. A list of hospitals using Kentile would take pages—because it is virtually wearproof, remarkably resists traffic abrasion).
5. Moisture resistance (Kentile is unharmed by moisture, can even be installed on concrete in direct contact with the earth).
6. Safety (Kentile is non-slippery and meets all fire underwriting requirements).
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Kentile is immediately available today, in any quantity, without reference to priorities.

Kentile will meet any design requirements. It is laid tile by tile; there are 15 sizes of tiles and each comes in 44 colors; there are no limits to the number of patterns possible.

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## Methodist Hospital Purchases Eye, Ear, Nose, Throat Unit

Purchase of the Memphis Eye, Ear, Nose and Throat Hospital, Memphis, Tenn., by the Methodist Hospital has been announced by the Methodist Hospital board of trustees, as a means of "extending a much needed service to the people of Memphis and the surrounding country."

The Eye, Ear, Nose and Throat Hospital is a 65 bed, three story building located half a mile from Methodist Hospital. The purchase price of the property was \$85,000.

Dr. Henry Hedden, administrator of Methodist Hospital, will also direct the eye, ear, nose and throat unit.

## Psychiatric Unit Opens in Memphis

Dedication exercises marked the opening of the Thomas Frank Gailor Psychiatric Hospital and Diagnostic Clinic as part of the John Gaston Hospital, Memphis, Tenn. Operating expenses of the new unit, except for staff salaries, will be handled through the Memphis and Shelby County Health Department. City, county and state funds were used to finance the \$515,000 building, four floors of which are to be used as an out-patient clinic and the other two as a psychiatric hospital.

## Daoust Heads Cleveland Clinic

The appointment of Edward C. Daoust as full-time head of Cleveland Clinic Foundation, which owns the Cleveland Clinic and its hospital, has been announced. Mr. Daoust succeeds Henry S. Sherman, who will become president of the board. The foundation is chartered as a nonprofit institution operated for scientific, charitable and educational purposes. After the war, it is reported, the foundation plans to erect additional stories on the new Cleveland Clinic Building.

## Hospital Plan for London

The King Edward's Hospital Fund for London on January 1 launched the Hospital Service Plan, designed as a nonprofit provident scheme to embrace the higher income groups that are outside the scope of contributory schemes. Beginning as a grant-in-aid plan, it is intended to serve as the foundation for a full-cover provident scheme after the war, according to the *Hospital*. Subscription rates range from £ 2 12 shillings annually (approximately \$11.50) for a single person to £ 5 5 shillings (about \$22.50) for a subscriber with four or more dependents. Payments are made for hospital treatment up to six weeks in any membership year, with a maximum of £ 105 (or about \$450).

## Temporary Wing to Be Added to Hospital in Bristol, Conn.


Construction of a new 50 bed wing of Bristol Hospital, Bristol, Conn., is planned to start immediately, with the approval of the War Production Board, which has granted the project an AA-4 priority rating, it has been announced. The project will provide a temporary, war-time addition consisting of one story and a basement; it will be built of stone, brick, mill and frame construction.

Critical materials will not be used in any part of the temporary structure and only the walls and foundations will be permanent enough to be retained after the war.

The cost of the addition has been estimated at \$152,000. A grant of \$67,641 was made to the hospital by the Federal Works Agency in November.

## Navy Publishes Corps Quarterly

In order to keep hospital corpsmen of the Navy informed regarding their duties, the Bureau of Medicine and Surgery of the Navy has resumed publication of the *Hospital Corps Quarterly*. The manual was first published in 1917 and was discontinued in 1930. Its purpose is to provide practical and useful information to hospital corpsmen and to assist in orientating corpsmen.



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TECHNICAL ADVANTAGES

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**Teeth always meet in accurate registering relationship.** The Serature Wound Clip is truly a precision instrument.

**Removed painlessly** by pressing together spurs on back of clip. Removal forceps or hemostat does not touch the open wound at any time.

Constructed of genuine, non-corrosive nickel silver. Can be used over again many times. Sold 20 clips to a wire holder; five holders to the box 12, 14, 16, 18 mm. sizes. Obtainable from surgical supply dealers; immediate delivery. Patented in U. S. and Canada. Write us for samples and full details, Dept. M.

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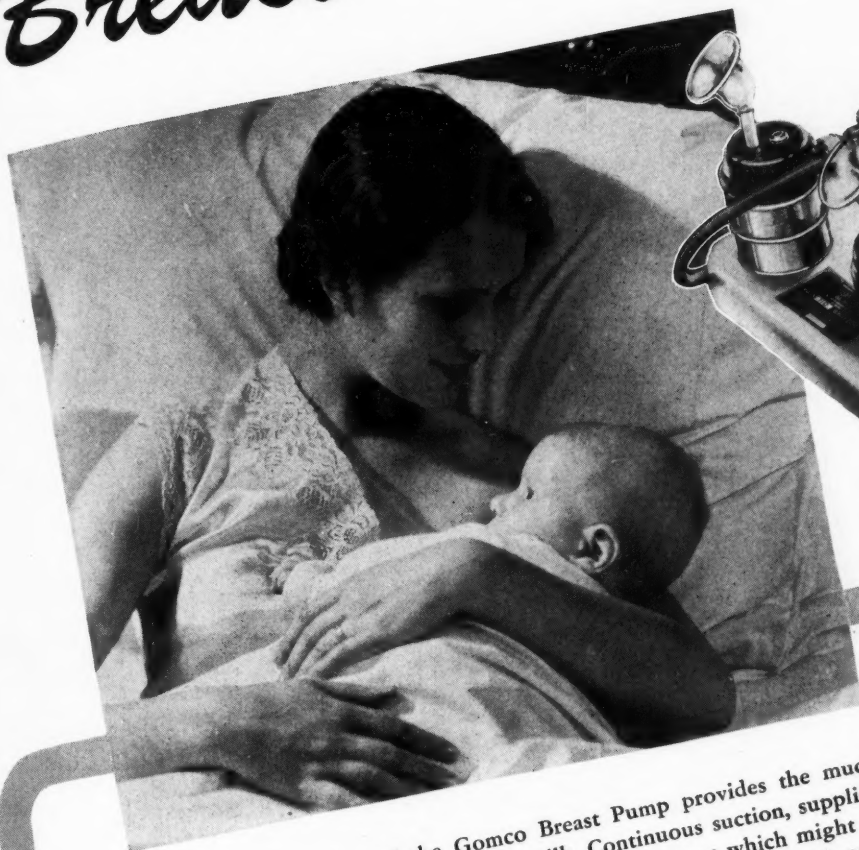
FOR over 40 years Colson has manufactured casters in hundreds of types and sizes. There's a Colson caster for every purpose, and throughout industry where jobs must be done in the shortest possible time, you'll find Colson casters on all kinds of equipment. • Today, we are supplying casters first where war needs demand them. Normal channels can be supplied only after war requirements are fully satisfied.

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No. 785

\*Meets requirements as outlined by Ritz E. Heerman, Supt. of the Calif. Hospital in Los Angeles, in his paper "Hazards in a Maternity Dept. by Use of Breast Pumps."

The unique operation of the Gomco Breast Pump provides the much desired safety in the taking of breast milk. Continuous suction, supplied by a rotary pump, prevents recirculation of air columns which might be contaminated by previous use. In addition to this all-important feature, the Gomco Breast Pump has a gentle action, controlled by the user, giving intermittent suction suited to individual needs and comfort. This practically eliminates nipple laceration. The Gomco Breast Pump is attractive in appearance, easy to use and clean. Completely equipped with two standard nursing bottles, suction line connection and sterilizable bottle covers. Details on request.

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## GOMCO BREAST PUMPS



## Additional Treatment Centers Set Up

A number of Rapid Treatment Centers to provide medical care for cases of early syphilis, gonorrhea and other venereal diseases are to be provided in several states, the Canal Zone and the Virgin Islands. Medical directors at the centers will avail themselves of the rapid treatment technics now being practiced, including four or five weeks' post-treatment observation.

## NAMES IN THE NEWS

### Administrators

**Dr. Jack Masur**, administrator of Lebanon Hospital, New York City, now serves in the Office of Civilian Defense in Washington, D. C., as a hospital administration specialist. **Lionel J. Simmonds**, former superintendent of the Hebrew Orphan Asylum in New York, will succeed Doctor Masur as Lebanon Hospital administrator.

**Dale L. Smith**, administrator of the Santa Fe Coast Lines Hospital, Los Angeles, and president of the Association of Western Hospitals, has been appointed executive assistant to the superintendent of charities and director of institutions of Los Angeles County, Calif.

## Honor Roll

Hospital administrators and assistant administrators serving in the armed forces:

### U. S. Army

**Wayne A. Copeland**, Wyoming County Community Hospital, Warsaw, N. Y.  
**William Corwin, M.D., (Capt.)**, Metropolitan State Hospital, Waltham, Mass.  
**Emanuel Giddings (Col.)**, Kings County Hospital, Brooklyn, N. Y.  
**Fred Graham (2nd Lt.)**, Evanston Hospital, Evanston, Ill.  
**C. E. Griffith (1st Lt.)**, Western Oklahoma Charity Hospital, Clinton, Okla.  
**C. A. Sharkey (Capt.)**, Good Samaritan Hospital, Phoenix, Ariz.

### U. S. Navy

**F. P. G. Lattner (Lt.)**, Iowa Hospital Service, Inc.

**I. Norman Downer**, a member of the executive committee of the Association of Western Hospitals and former business manager of the Santa Clara County Hospital, San Jose, Calif., has received a commission as captain in the Medical Administrative Corps of the Army.

**C. E. Griffith**, superintendent of Western Oklahoma Charity Hospital and business manager of the Western Oklahoma Tuberculosis Sanatorium, Clinton, Okla., has been commissioned first lieu-

tenant in the medical hospital replacement corps. **Thomas C. Black, M.D.**, newly appointed superintendent of the sanatorium, will assume the duties of business manager. **Dr. W. H. Smith**, medical adviser for the Western Oklahoma Charity Hospital, will serve as acting superintendent there.

**Joseph A. Giant**, superintendent of the County Infirmary, Fort Wayne, Ind., has resigned in order to resume active management of his farm.

**Robert A. Gaughan**, superintendent of the Hazleton State Hospital, Hazleton, Pa., has completed his term of service and will now devote his time to the surgical and medical supervision of the hospital. **Charles L. Wilde** has assumed the superintendency.

**Dr. Martin H. Hoffman**, director of the psychiatric clinic at Eloise Hospital and Infirmary and head of the County Psychopathic Parole Clinic, Eloise, Mich., has resigned.

**Wayne A. Copeland**, for the last fourteen years superintendent of the Wyoming County Community Hospital, Warsaw, N. Y., has resigned to enter the Army Medical Administration Corps.

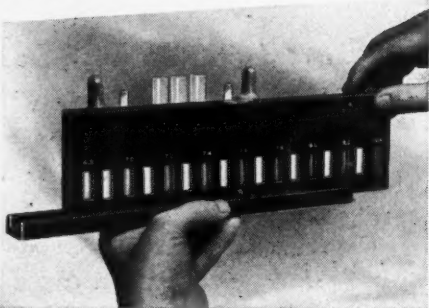
**Dr. Patrick J. Meehan** has resigned his position as assistant superintendent of Tewksbury State Hospital and Infirmary, Tewksbury, Mass.

**Hazell M. Gosnell, R.N.**, is the new

## Speedy Sulfa Determinations

WITH ONLY  
0.1 cc of BLOOD

Increase the efficiency of your laboratory! Now, through a new method developed by Drs. Churg and Lehr, of Newark Beth Israel Hospital, you may make accurate sulfa determinations in from 6 to 8 minutes. Using the Taylor Sulfanilamide Comparator, you simply add reagent to blood sample, filter, add the second reagent, move slide until color match is obtained and read off sulfa content directly from values on the slide. Sulfapyridine, sulfaguanidine, sulfathia-



zole and sulfadiazine may be determined with the same outfit. All color standards carry AN UNLIMITED GUARANTEE AGAINST FADING.

*This same set may be used for Urea Nitrogen and Urine pH simply by procuring additional slides and accessories.*

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Our men in training camps and combat zones need the fullest measure of protection from disease carrying insects. Hence there is to be found on every fighting front America's most effective insect exterminating combination — the Tanglefoot Difusor and Difuso. If you are one of the fortunate thousands owning a Difusor, take good care of it. Don't take a chance on ruining its highly efficient mechanism by using in it anything but genuine Difuso.

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## SUPPLIES FOR VICTORY...

Supplies that are carefully made, sturdily constructed for long service—scultetus binders, breast binders, male and female T binders, abdominal binders, pneumonia jackets and other Marvin-Neitzel surgical accessories designed to specifications and approved by surgeons and hospital executives. The material of which they are made is the highest quality obtainable for the purpose, reinforced against strain, stitched with strong three cord thread. It will pay you to buy Marvin-Neitzel surgical accessories.

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**TROY-NEW YORK**

administrator of Glenville Hospital, Cleveland. She was formerly director of the hospital's school of nursing.

**Helen Card, R.N.**, has been selected as the administrator of Port Huron Emergency Hospital, Port Huron, Mich.

**Lt. Clement C. Clay** has been promoted to the rank of lieutenant commander in the U. S. Naval Reserve Medical Corps and is stationed at Trinidad, British West Indies.

**C. A. Sharkey** is a captain in the Army Medical Administrative Corps and is stationed at Finney General Hospital, Thomasville, Ga.

**Richard J. Connor**, formerly assistant administrator at the University Hospitals, Iowa City, Iowa, has recently been appointed administrator of the Ellis Fischel State Cancer Hospital, Columbia, Mo.

**Dr. Israel Magelaner**, formerly medical superintendent of Harlem Hospital, New York City, has been appointed medical superintendent of Kings County Hospital, Brooklyn, N. Y. He succeeds **Emanuel Giddings, M.D.**, now in the Army Medical Corps. **Dr. Emanuel W. Lipschutz**, acting medical superintendent at Kings County Hospital, is now medical superintendent of the Harlem Hospital.

**Fred Graham**, assistant administrator at Evanston Hospital, Evanston, Ill., has

been commissioned second lieutenant in the Army Medical Administration Corps. **Richard Highsmith**, who has been administrative intern at the hospital, is taking his place.

**Roland A. Scott** is the new director of the Iroquois Hospital, Watseka, Ill.

**Leon S. Lippincott, M.D.**, is serving as a pathologist at the Eastern Maine General Hospital, Bangor, Me.

**Hulda C. A. Fleer**, who has been head of Aultman Hospital, Canton, Ohio, for almost twenty years, resigned recently.

#### Department Heads

**Margaret M. Ingersoll**, who was director of instruction at the Children's Memorial Hospital, Chicago, for eleven years, became director of nursing at Children's Hospital, Philadelphia.

**Mrs. Roland Saeger** has been selected superintendent of nurses at Dodge County Hospital, Fremont, Neb. Mrs. Saeger served as superintendent of nurses at the former Good Samaritan Hospital in the same city.

**Albia M. Rowan** is the new superintendent of nurses at Bryan Memorial Hospital at Lincoln, Neb., replacing **Dorothea Mortensen**.

#### Miscellaneous

**F. P. G. Lattner**, executive director of Hospital Service Inc. of Iowa, has

been granted a leave of absence to become a lieutenant in the U. S. Naval Reserve. During his absence **E. P. Lichty** will serve as acting executive director.

#### Deaths

**Cecil Sparks**, medical supervisor at the Methodist Hospital in Fort Wayne, Ind., died recently of a heart attack.

**Charles Willing Hare**, managing director of Bryn Mawr Hospital, Bryn Mawr, Pa., died at the age of 71.

**Rev. Mother M. Regis Starr**, sister superior at Sacred Heart Hospital, Manchester, N. H., died after a short illness.

**Emma Dunn**, former assistant superintendent of nurses at Rhode Island Hospital in Providence and nursing director of Crawford Allen Memorial Hospital, East Greenwich, R. I., died following a long illness.

**Emma M. Nichols**, for many years superintendent of nurses at Boston City Hospitals, died recently.

**Elizabeth Dorathea Donet**, former superintendent of hospitals at both Mount Pleasant and Latrobe, Pa., died recently in Mc Keesport, Pa.

**Dr. George W. Crile**, co-founder of the Cleveland Clinic in Cleveland, died at the clinic where he had been under observation for a heart ailment for three weeks.

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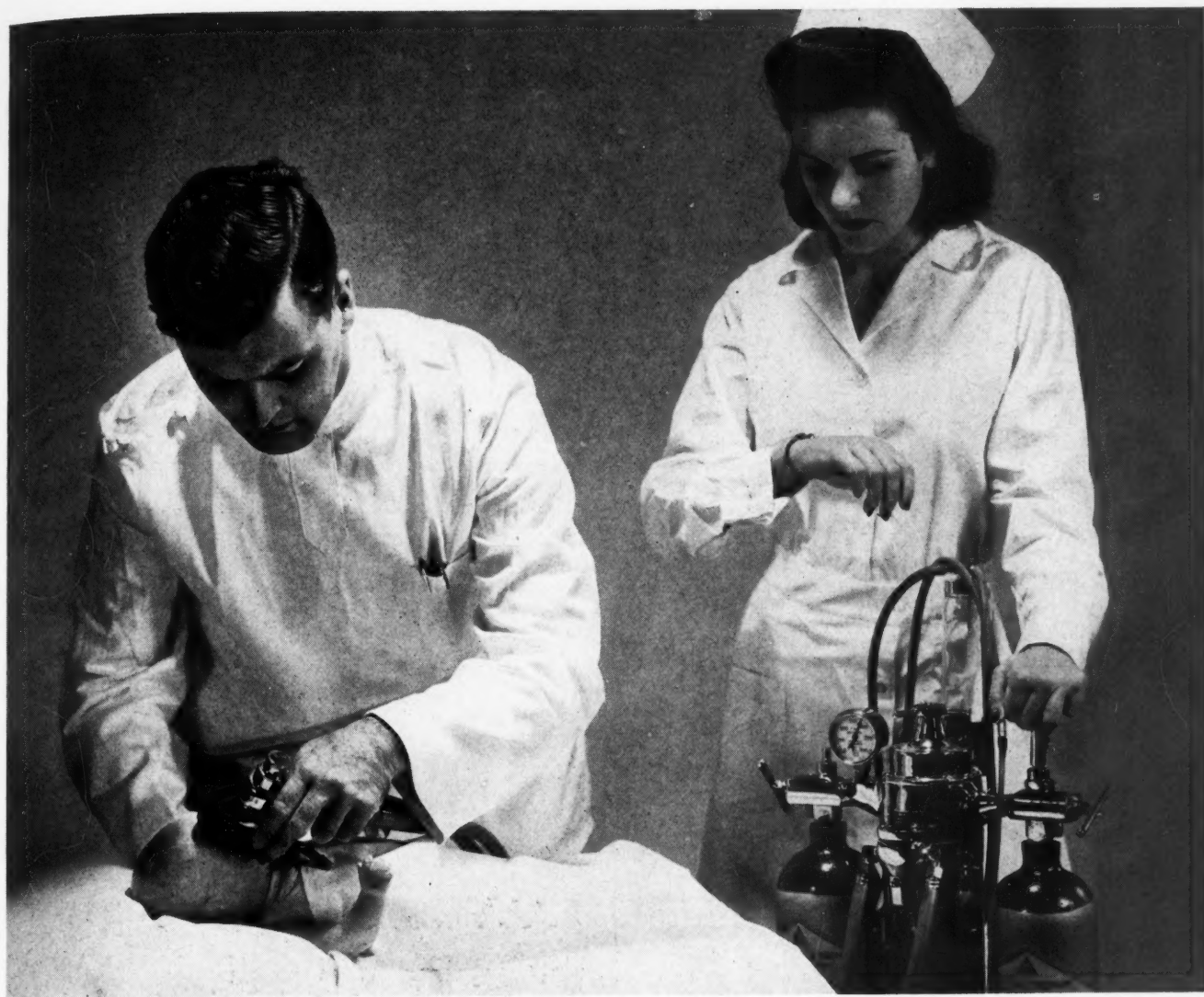
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## THE BOOKSHELF

PHYSICIANS' REFERENCE BOOK OF EMERGENCY MEDICAL SERVICE. *New York: E. R. Squibb & Sons., 1942. Pp. 268.*

This not only is a physicians' reference book but also has one of its three sections devoted to hospital services; material in other sections also deals with hospitals. It comprises excerpts from medical literature, largely British, presenting the practical experience and lessons learned in the handling of civilian war casualties. Four fifths of it has been derived from foreign sources not readily available in this country.

The book contains no advertising and is published as a public service and apparently without charge by Squibb.

200 WAYS TO REDUCE ENGINEERING AND MAINTENANCE COSTS IN HOTELS, HOSPITALS, APARTMENTS AND INSTITUTIONS. *By A. N. Brent, E. F. Dowis, Fred D. Mosher and Martin J. Peterson. Stamford, Conn.: The Dahls, 1942. Pp. 144. \$1.*

A book such as this one should be in the possession of every chief engineer and building superintendent. Even though he may feel that he knows all the things it contains, yet he must admit

that he has forgotten or has taken for granted many of them. The book is short and to the point. Some of the sections included in the book are: "30 Ways to Reduce Air Conditioning Costs"; "30 Ways to Reduce Refrigeration Costs"; "Tested Ways to Control Cost of Electricity"; "The Engineer and the Food Department," and "50 Maintenance Tips."

The last section, on Posters, is a fitting conclusion to a well-organized book to which an engineer will often refer.—LELAND J. MAMER.

HOW TO ORGANIZE GROUP HEALTH PLANS. *By Martin W. Brown, LL.B., Katharine G. Clark, Perry R. Taylor, Joint Committee of the Twentieth Century Fund and the Good Will Fund; and Medical Administration Service, Inc., 1942. Pp. 72. \$0.25.*

The authors point out that there are six types of health service plans: (1) Commercial—under insurance companies. (2) Industrial—operated in an industrial plant by owners, employees or both. (3) Private medical groups—organized by a group of physicians. (4) Medical societies—sponsored by state or

local medical societies. (5) Hospital plans—organized by the hospitals themselves (most of these are approved by the American Hospital Association and are referred to as Blue Cross plans). (6) Cooperative—organized by a labor union, a fraternal body, a consumers' cooperative or any other group representing the prospective patients themselves.

The book deals almost entirely with the cooperative or consumer type of group health plan and only occasional reference is made to the five other types of plans.

The three authors have done an excellent job in outlining the various steps to be followed by any consumer group interested in developing a medical or hospital service plan. They deal with the first steps of organization, the legal right to organize such plans, the legal framework of such an organization, the selection of membership in the consumer organization, the problem of financing and, finally, the legal problems of organizing plans.

The three chapters on legal phases of organizing and operating such plans will be of interest to everyone interested in the broad problem of developing methods to enable people to budget the cost of health services.—JOHN R. MANNIX.

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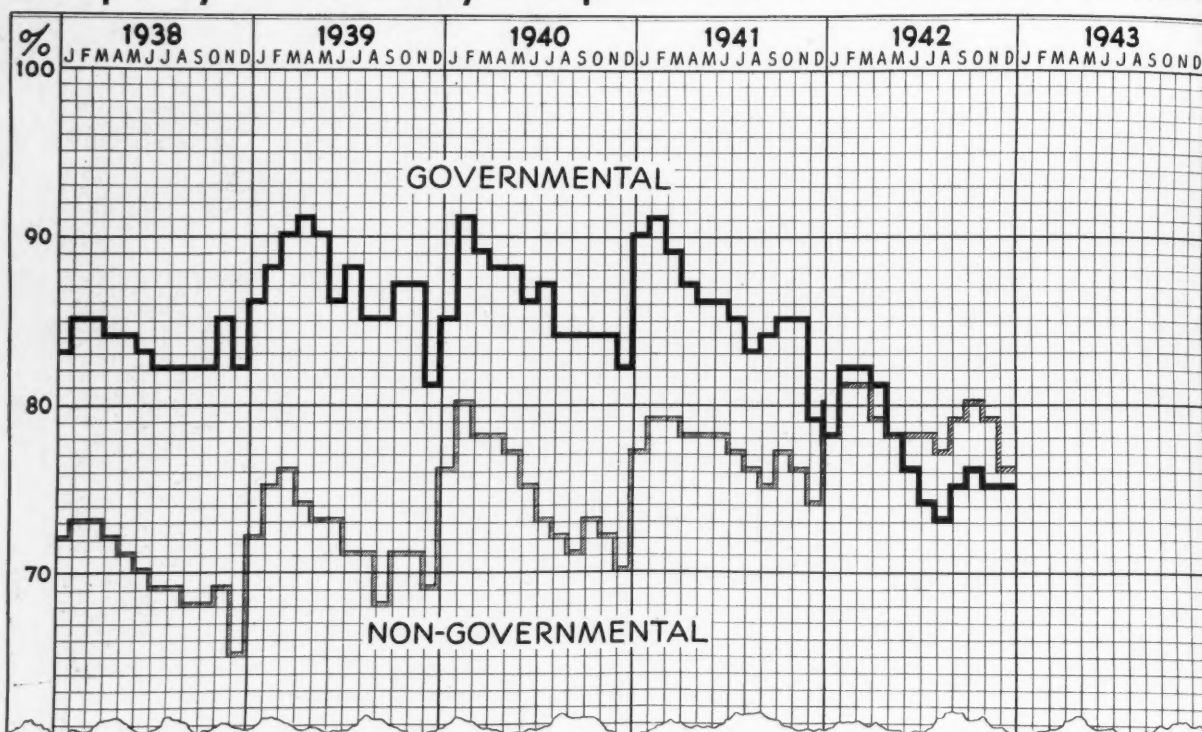
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## Occupancy in Voluntary Hospitals Above Government Level

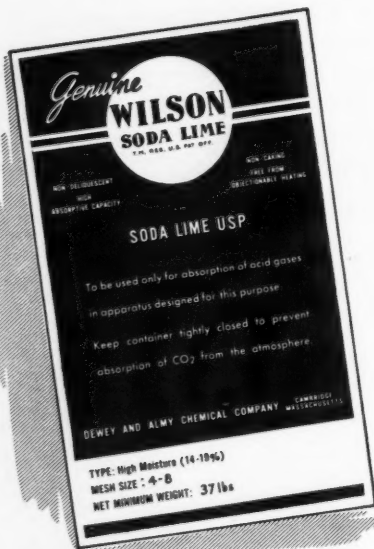


Occupancy in voluntary hospitals dropped in December but remained two points higher than a year earlier. In the governmental general hospitals occupancy was down two points from 1941. During

1942, for the first time since the depression ended, voluntary hospitals had higher occupancy than governmental institutions.

From December 15 to January 25 a

total of 20 new building projects was announced of which 18 gave costs of \$5,053,021. During the same period, however, 23 projects involving \$7,118,267 were postponed for the war.



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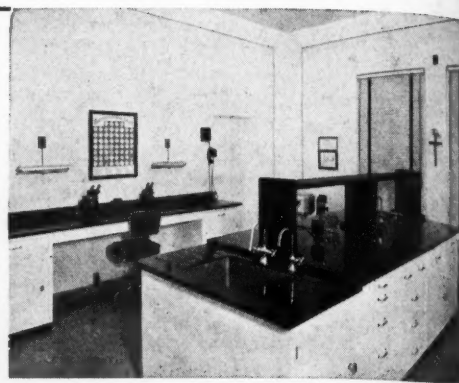
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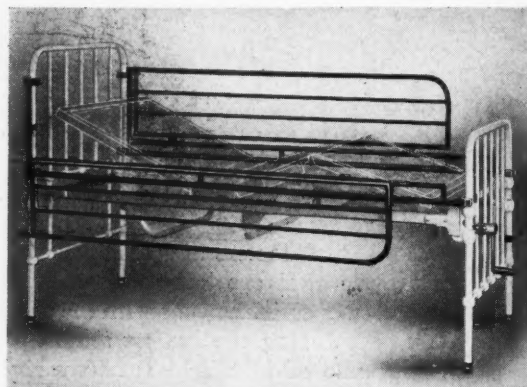


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